

VR A15 (4)
20 M 1/66

centa
MEDICAL CERTIFICATION

1

12533

CERTIFICATE OF DEATH

12542

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>162</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>		d. STREET ADDRESS <u>8811 ENFIELD COURT</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DEBORAH LYNN ALBERTS</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/23/66</u>	
9. AGE (In years last birthday) <u>1 yr. Yrs.</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>	
11. IF UNDER 24 HRS. Hours <u>14</u> Min. <u>67</u>			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11c. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>---</u>	
13. FATHER'S NAME <u>GEORGE E ALBERTS</u>		14. MOTHER'S MAIDEN NAME <u>TERESSA MERRICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>#13</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7441 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Muscular Dystrophy</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>---</u> o.m. <u>---</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 13, 1967</u> , to <u>Sept 13, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept 13, 1967</u> , and that death occurred at <u>---</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Albert J. Moolin MD</u>		22b. DATE SIGNED <u>9-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT J MOOLIN MD</u>		22d. ADDRESS <u>704 GORMAN AVE LAUREL MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>---</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>---</u>		23d. LOCATION (City or Town) (County) (State) <u>SPOKANE WASH.</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to your papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12534		12542	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN lb <u>7 days</u>		d. STREET ADDRESS <u>1507 Whippoorwill Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Beatrice Ann Allcock</u>		4. DATE OF DEATH Month Day Year <u>September 27 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 December 1934</u> 32 yrs.
9. AGE (In years last birthday) <u>32</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew J. Orlosky</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Hunter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Records</u>		18. ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas (Wide spread Metastases)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>9 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>27</u>
21. I certify that (X) (this hospital) attended the deceased from <u>September 20 1967</u> , to <u>September 27 1967</u> , that (X) (we) last saw the deceased alive on <u>September 27 19 67</u> , and that death occurred at <u>2:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Michael Emmer</u>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>27 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michael Emmer, MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>OCT 2 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
12535 CERTIFICATE OF DEATH 12544					
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home			d. STREET ADDRESS 304 69th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Linda Middle B. Last Amos			4. DATE OF DEATH Month September Day 20 Year 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-1886	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Samuel Redding			14. MOTHER'S MAIDEN NAME Jenny Ellyson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Raymond H. Amos Address 304 69th Place Seat Pleasant	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebral vascular accident 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular arteriosclerosis DUE TO (c) Generalized arteriosclerosis DUE TO					INTERVAL BETWEEN ONSET AND DEATH 15 yrs 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-16-67 , to 9-20-67 , that (I) (we) last saw the deceased alive on 9-16-67 , and that death occurred at 9-20-67 M, from causes and on the date stated above.					
22a. SIGNATURE Peter Duus			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 20, 1967
22c. PHYSICIAN'S NAME (Type) Peter Duus, M.D.			22d. ADDRESS 6124 Central Ave. Capital Hgts. Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-22-1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland			25a. REC'D BY REGISTRAR DATE SEP 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

Montgomery

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Abstract

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Editor Will Quinlan

Study	Design	Subjects
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1

12536

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12545

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges <i>Chas.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road <i>08.2</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS Route 1 Box 147		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARVEY ROBERT ARNOLD <i>First Middle Last</i>				4. DATE OF DEATH Month 9 Day 30 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-1902	
9. AGE (In years last birthday) yrs. 65		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Circus Worker		10b. KIND OF BUSINESS OR INDUSTRY Marshall Hall		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robert H. Arnold			
14. MOTHER'S MAIDEN NAME Glennie V. Coates				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Maryland Evelyn V. Moore 3509 79th Ave Forestville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguinating hemorrhage due</i> DUE TO <i>to hemorrhagic diathesis status</i> DUE TO <i>post aortagraft embolus</i> DUE TO <i>post aortagraft embolus</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <i>Chas</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/29 , 19 67 , to 9/30 , 1967, that (I) (we) last saw the deceased alive on 9/30 , 1967, and that death occurred at 1967 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Frederick Y. Donn</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frederick Y. Donn				22d. ADDRESS <i>1000 Connecticut Ave. Kensington, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-3-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm <i>Funeral Home</i> 4308 Suitland Road Suitland Maryland				25a. REC'D BY REGISTRAR DATE OCT 5 1967		25b. REGISTRAR'S SIGNATURE <i>Frederick Y. Donn</i>	

5021-5-00

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12537					12548				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY MONT				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN lb 1 Hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs 151				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital, Bethesda, Md.					d. STREET ADDRESS 8201 16th Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Asher BADT					4. DATE OF DEATH Month September Day 8th Year 1967				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 SEP 1884		9. AGE (In years last birthday) yrs. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy			10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) TYLER TEXAS			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph BADT					14. MOTHER'S MAIDEN NAME Ida SPIRO				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. (If yes give war or dates of service) 578-40-9963		17. INFORMANT Jennie (NMN) BADT 8201 16th St. Md.			Address Silver Springs, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Advanced Coronary Arteriosclerosis DUE TO (c) Coroner notified at 2115 8 Sept 1967					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 SEP 1967 to 8 SEP 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8 SEP 1967 , and that death occurred at 7:21 P.M. from causes and on the date stated above.									
22a. SIGNATURE E. VAN HOVE for LEDR MC					22b. DATE SIGNED 9 Sept 1967			22c. PHYSICIAN'S NAME (Type) M.D.R. FOREMAN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, or other disposition Burial			23b. DATE THEREOF 12 SEP 1967		23c. NAME OF CEMETERY OR CREMATORY Arlington, National			23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Goldberg Funeral Home					25a. REC'D BY REGISTRAR DATE SEP 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

(1970) 1970

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D. H. WONG

U. S. Navy Hospital, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

12538		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12547	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Washington D.C.</i> b. COUNTY <i>20006473</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>3 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C. 20006473</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Gardens Sanitarium</i>		d. STREET ADDRESS <i>2122 CALIFORNIA ST. N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frances BAHN Bailey</i>		4. DATE OF DEATH <i>September 10 1967</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/12/1889</i>	9. AGE (In years last birthday) <i>78 yrs.</i>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (County & State, or foreign country) <i>PENNA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>Charles Eugene Bahn</i>		14. MOTHER'S MAIDEN NAME <i>HAVANA HAR Bold</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>WA 507757</i>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> <i>5271</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>pulmonary embolism</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>arteriosclerotic cerebral vascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>8/21</i> , 19 <i>67</i> , to <i>9/10</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9/10</i> , 19 <i>67</i> , and that death occurred at <i>1:30 AM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>H F Kreuzburg</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9/10/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>H F Kreuzburg</i>		22d. ADDRESS <i>7852 16th NW Wash D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>Sept 11, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery Wash D.C.</i>	
23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <i>Harold S. Wad, Laurel Md</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 13 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 12 Macgill Avenue	
3. NAME OF DECEASED (Type or print) First Mackey Middle Lee Last Baliles		4. DATE OF DEATH Month September Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-97
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C. Transit-retired		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Barney Baliles		14. MOTHER'S MAIDEN NAME Lucinda Foley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-10-5979h	
17. INFORMANT Patinet's chaft		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 67 , to 9/15 , 19 67 , that (I) (we) lost saw the deceased alive on 9/15/67 19 67 , and that death occurred at 3:42 A.M. from causes and on the date stated above.			
22a. SIGNATURE Alan R. Gair		22b. DATE SIGNED 9/15/67	
22c. PHYSICIAN'S NAME (Type) Alan R. Gair M.D.		22d. ADDRESS 7777 Maple Ave, Takoma Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Md	
24. FUNERAL DIRECTOR J. Arthur Miller		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C.

February 1, 1954

Mr. J. Edgar Hoover

Director, FBI

Dear Sir:

Reference is made to your letter of January 28, 1954, regarding the above captioned matter.

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being furnished to the Bureau for your information and for the Bureau's files.

Very truly yours,

1

100-3-1

White

Enclosure

Very truly yours,

W. A. Rorer

Special Agent in Charge

100-3-1

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						d. STREET ADDRESS <u>6821 Wilson Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>F.</u> Middle <u>Barbee</u> Last						4. DATE OF DEATH <u>Sept. 20</u> Month <u>1967</u> Day <u>1967</u> Year					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-28-1919</u>		9. AGE (In years lost birthday) <u>48</u> yrs.		IF UNDER 1 YEAR: Months <u>48</u> Days <u>48</u> Hours <u>48</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pres. Barbee Curran Sales. Co. Glenview</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Barbee, John E.</u>						14. MOTHER'S MAIDEN NAME <u>Poore, Martha Anna</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-12-4880</u>		17. INFORMANT <u>W. Lee Helen Kuldell Barbee</u> Address <u>Bethesda #2.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction due to Coronary</u> <u>4201</u> DUE TO <u>Arteriosclerosis with Thrombosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 1967</u> to <u>Sept 20 1967</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>George Sharpe</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>George Sharpe, M.D.</u>						22d. ADDRESS <u>10400 Conn. Ave. Kensington, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9-25-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery/ Silver Spring, Md.</u>				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				ADDRESS <u>5130 Wisc. Ave. N.W.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. George</u>			

VI

STATE OF TEXAS

County of _____

State of Texas

1967-12-20

CERTIFICATE OF DEATH

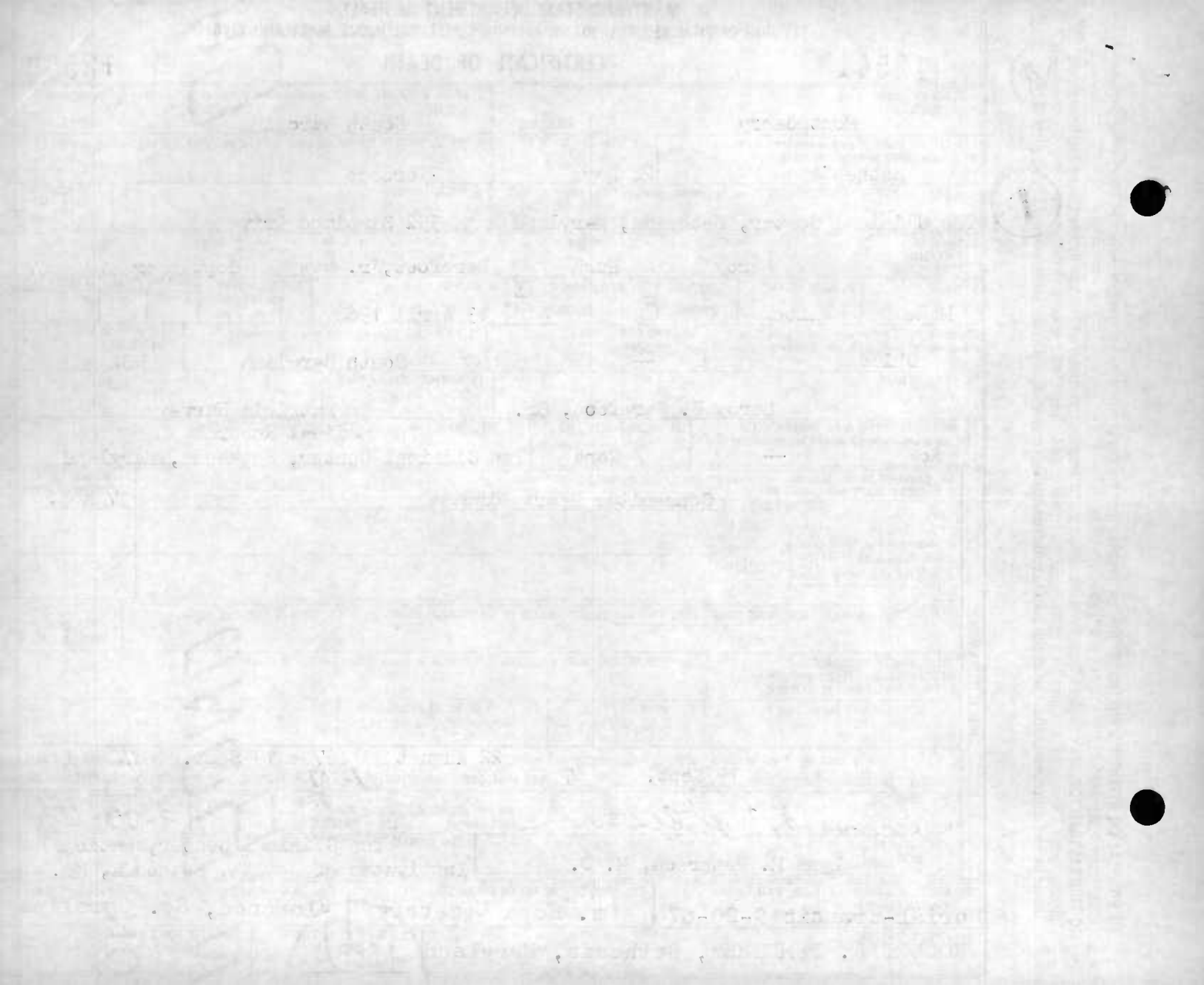
12541

12550

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>South Carolina</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>28 Days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Florence</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			d. STREET ADDRESS <u>552 Santiago Drive</u>		
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>Hugh</u> Last <u>Barefoot, Jr.</u>			4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 April 1966</u>		9. AGE (In years lost birthday) <u>1</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>Leroy H. Barefoot, Sr.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>The Medical Records</u>			18. ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>7545</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>17 Mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>22 August</u> , 19 <u>67</u> , to <u>19 Sept.</u> , 1967, that <input checked="" type="checkbox"/> (we) lost the deceased alive on <u>19 Sept.</u> , 19 <u>67</u> , and that death occurred at <u>12:07 M.</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Lynn M. Peterson</u>		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <u>Lynn M. Peterson, M. D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>		22b. DATE SIGNED <u>9-19-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 9-20-67</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	23d. LOCATION (City or Town) <u>Florence, So. Carolina</u>	(County)	(State)
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 25 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12542

CERTIFICATE OF DEATH

12551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>15105 Hildegard Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Frank James Barr</u>		4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-23-83</u> 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US GOVERNMENT</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL Samuel Barr</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH Gunther</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-50-8352</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1992</u> IMMEDIATE CAUSE (a) <u>Congestive heart failure.</u> DUE TO (b) <u>Pulmonary Edema</u> DUE TO (c) <u>metastatic Ca - undetermined primary</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>66</u> , to <u>Sept 1</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>Sept 1</u> 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>		22d. ADDRESS <u>Burtonsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel Grove Pike, Ohio</u>
24. FUNERAL DIRECTOR <u>DeWitt Donaldson Laurel, Md.</u>		25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

1932

Birth of a child
born to the wife of
John J. Smith
born at Columbus, Ohio
on the 15th day of
January, 1932
at 10:30 A.M.
weight 7 lbs.
length 20 inches
color of hair brown
color of eyes blue

(1)

Signature of Registrar
Date of registration
15 Jan 1932
Signature of Physician
Signature of Mother
Signature of Father

12552

12543

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Fulton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>493</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Palomar Valley Nursing Home</u>		d. STREET ADDRESS <u>1229 Virginia Ave NE</u>	
3. NAME OF DECEASED (Type or print) <u>Minnie S. Borsett</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13 1892</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Macon Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levin S. Holloway</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>417484582</u>	
17. INFORMANT <u>Mrs. Harold Kopp</u>		Address <u>619 Wopel Dr Rockville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Primary Carcinoma of the Lung</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1967, to <u>Sept 11</u> , 1967, that (I) (we) last saw the deceased alive on <u>Sept 7</u> , 1967, and that death occurred at <u>2P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William H. Killian</u>		22b. DATE SIGNED <u>Sept 11 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William H. Killian</u>		22d. ADDRESS <u>8218 Waco Ave Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEM. ATLANTA</u>	23d. LOCATION (City or Town) (County) (State) <u>Georgia</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>		DATE <u>SEP 14 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1912
The following is a list of the names of the persons who have been appointed to the various positions in the Department of Agriculture for the year 1912.
The names are arranged in alphabetical order.
The names of the persons who have been appointed to the positions of Assistant Secretary, Chief Clerk, and Chief of the Bureau of Plant Industry are given in italics.
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1912
The following is a list of the names of the persons who have been appointed to the various positions in the Department of Agriculture for the year 1912.
The names are arranged in alphabetical order.
The names of the persons who have been appointed to the positions of Assistant Secretary, Chief Clerk, and Chief of the Bureau of Plant Industry are given in italics.
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The names of the persons who have been appointed to the positions of Assistant Secretary, Chief Clerk, and Chief of the Bureau of Plant Industry are given in italics.

12553

12544

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b Rockville		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13516 Glen Mill Road				d. STREET ADDRESS 13516 Glen Mill Road	
3. NAME OF DECEASED (Type or print) First Middle Last William W. Bartlow		4. DATE OF DEATH Month Day Year Sept. 13, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1880		9. AGE (In years last birthday) yrs. 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Richard Bartlow			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 186-01-5516		17. INFORMANT Mrs Russell Sweeney-Item # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) Many yrs.					INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes; cerebral arteriosclerosis; old fractured hip, pulm. fibrosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct. 11, 1965 , to Sept. 13, 1967 , that (I) (we) last saw the deceased alive on July 20, 19 67 , and that death occurred at 9 A.M. from causes on and on the date stated above.					
22a. SIGNATURE <i>Sydney O. Cohen</i>				22b. DATE SIGNED Sept. 13, 1967	
22c. PHYSICIAN'S NAME (Type) Sydney O. Cohen				22d. ADDRESS 50 W. Edmondston Drive, Rockville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/67		23c. NAME OF CEMETERY OR CREMATORY Rose Lawn	
		23d. LOCATION (City or Town) (County) (State) Berwick, Pennsylvania			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Maryland				25a. REC'D BY REGISTRAR SEP 15 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation	
John Doe		12/15/1925		Male		White		Married		Farmer	
Place of Birth		Date of Death		Time of Death		Cause of Death		Place of Death		Manner of Death	
Farm, Iowa		10/10/1975		10:30 AM		Heart Disease		Home		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Burial Officer		Signature of Funeral Home		Signature of Cemetery	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Certificate		Name of Registrar		Name of Informant		Name of Burial Officer		Name of Funeral Home	
10/15/1975		Farm, Iowa		John Doe		John Doe		John Doe		John Doe	

John Doe

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

12545

12554

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

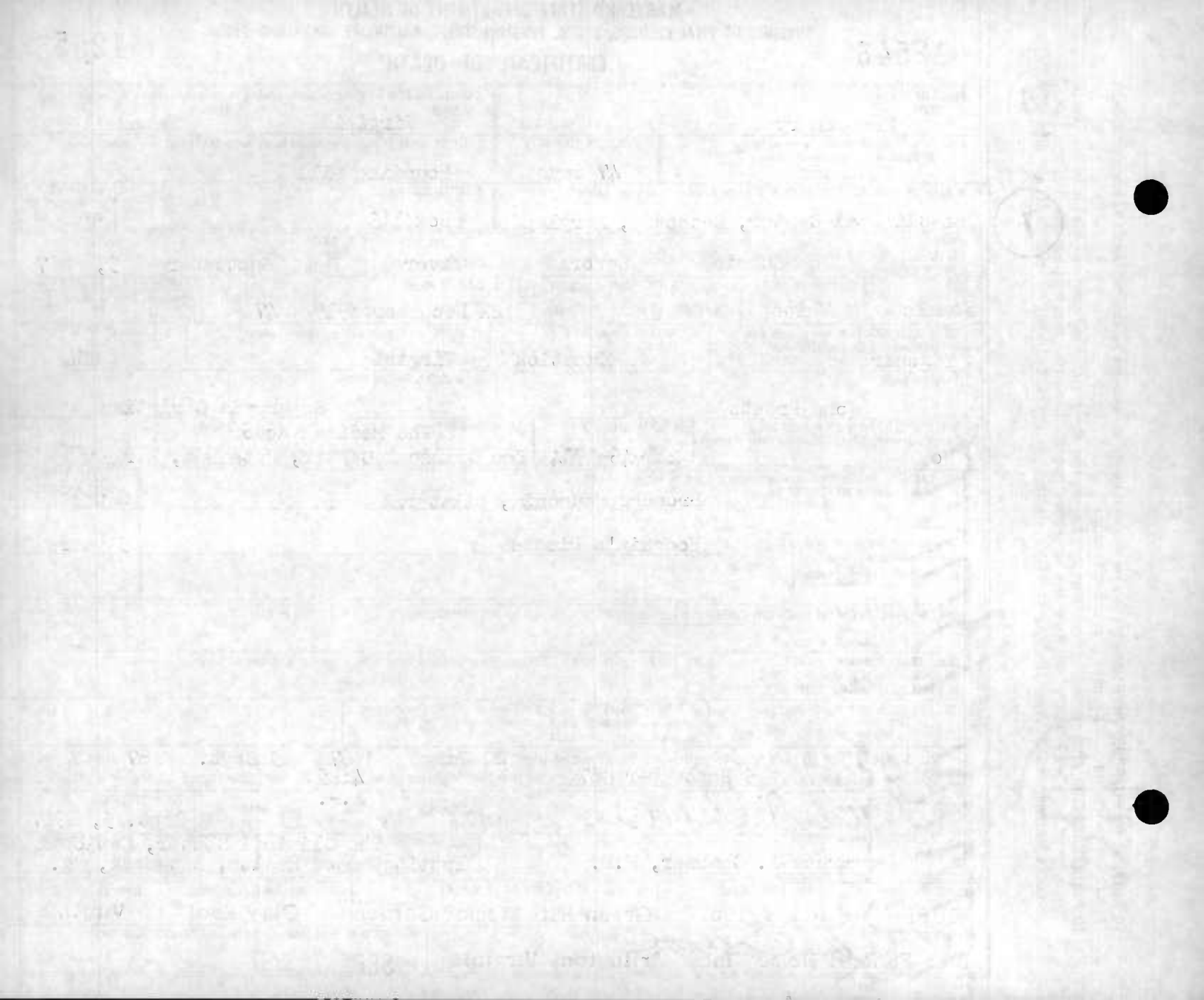
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 4314 Kaywood Dr. #101	
3. NAME OF DECEASED (Type or print) Philip Henry Bath		4. DATE OF DEATH Month September Day 7 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/00
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	
11. BIRTHPLACE (State or foreign country) Pittston, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bath		14. MOTHER'S MAIDEN NAME unknown (died at birth)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II 577 07 80 32	
17. INFORMANT Daughter,		Address 12814 Turkey Br. Pkwy. R vl., Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4222 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Chronic myocardial infarction DUE TO (c) 3 weeks		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John S. Rogers, Jr. M.D.		22. DATE SIGNED 9-7-67	
EXAMINER'S NAME (Type) John S. Rogers, Jr.		Address, Street, City, State, and County	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Pro Georges Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12555							
12546						CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Tazewell</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>47 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pounding Mill</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			d. STREET ADDRESS <u>Box 113</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Gussie</u> Middle <u>Lenora</u> Last <u>Beavers</u>			4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1967</u>								
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 December 1919</u>		9. AGE (In years last birthday) <u>47</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>							
13. FATHER'S NAME <u>John Pruett</u>			14. MOTHER'S MAIDEN NAME <u>Sophonra Christian</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>228-46-1984</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> DUE TO (b) <u>Hodgkin's Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 years</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>20 July</u> , 19 <u>67</u> , to <u>5 Sept.</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5 September 1967</u> , and that death occurred at <u>4:25 M</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Bruce A Chabner</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Sept. 5, 1967</u>							
22c. PHYSICIAN'S NAME (Type) <u>Bruce A. Chabner, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/7/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Memo. Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Clay Pool Virginia</u>							
24. FUNERAL DIRECTOR <u>Ives Funeral Home, Inc.</u>		ADDRESS <u>Arlington, Virginia</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>						



12547

CERTIFICATE OF DEATH

12556

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

clear with medical examiner

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>9005 - Kirkdale St.</u>	
3. NAME OF DECEASED (Type or print) <u>Richard W. Beers</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 18, 1911</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronic Air Instrument</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland, U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Nelson Beers</u>		14. MOTHER'S MAIDEN NAME <u>Stella Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>577-07-1094</u>	
17. INFORMANT <u>Helen M. Beers</u>		Address <u>As above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>6 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>8/30</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 9/1</u> , 19 <u>66</u> to <u>8/30</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/30</u> , 19 <u>67</u> , and that death occurred at <u>4:05</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>H. F. Kreuzburg</u>		22b. DATE SIGNED <u>9/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>		22d. ADDRESS <u>2852 16th Ave NW, Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND MARYLAND</u>	
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SONS, INC.</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1967</u>	
ADDRESS <u>WASHINGTON, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF SALE

1904



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

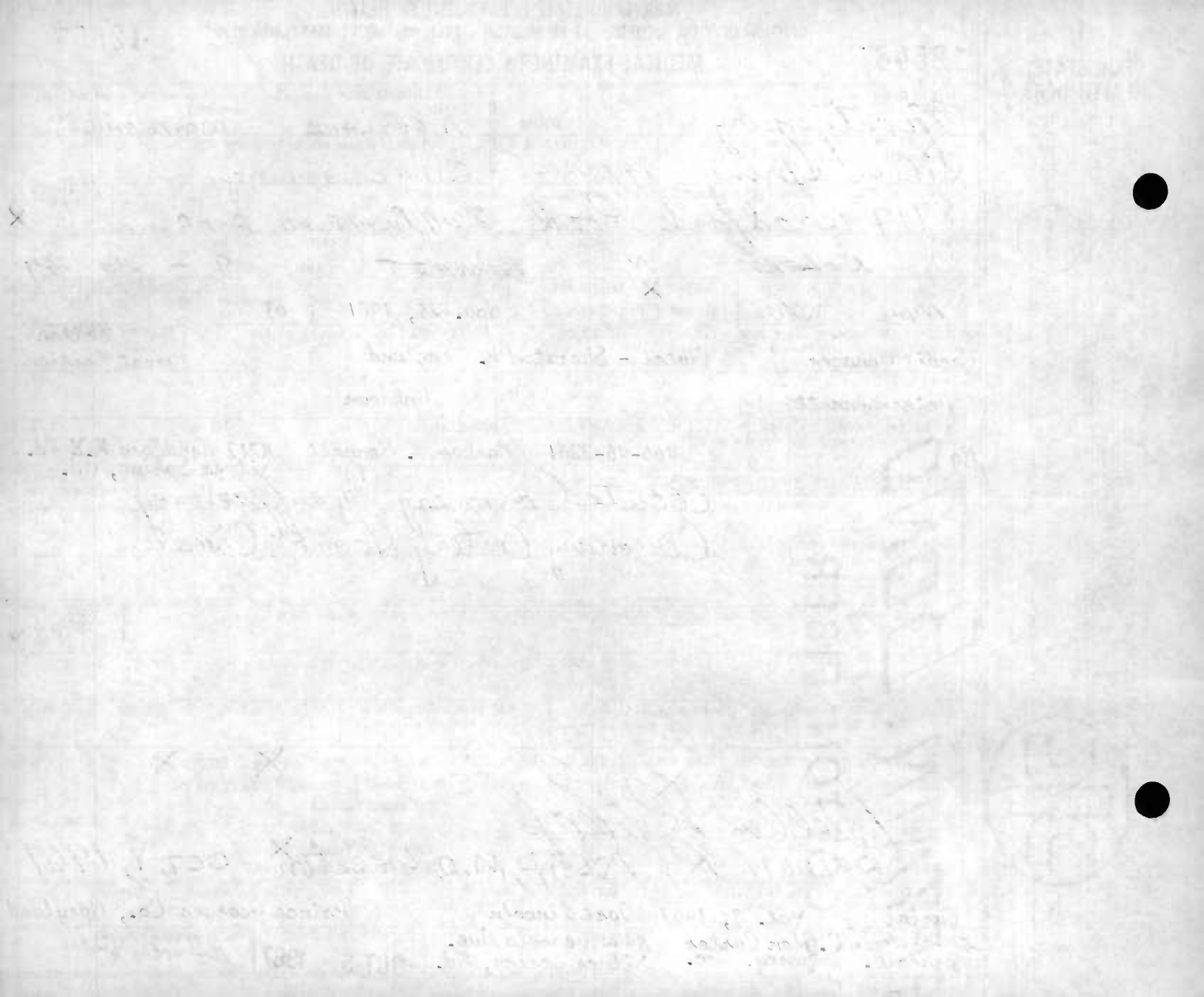
12548

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12557

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>14 YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8717 Bradford Road</u>		d. STREET ADDRESS <u>8717 BRADFORD ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>ROBERT W. BENNETT</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>30</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1901</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>30</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel - SheratonPk.</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF COUNTRY <u>Great Britain</u>	
13. FATHER'S NAME <u>Peter Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>466-46-2261</u>	
17. INFORMANT <u>Barbara U. Bennett</u>		Address <u>8717 Bradford Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>OCT. 1, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		Address <u>Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Maryland</u>	
24a. FUNERAL DIRECTOR <u>C. Glen Carter</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	
Address <u>8474 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 5 1967</u>	



CERTIFICATE OF DEATH

12549

12558

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN lb <u>21 HRS.</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>5907 - Wilmett Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>W.</u> Middle <u>Bentz</u> Last		4. DATE OF DEATH <u>Sept. 7</u> Month <u>7</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/11</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractors</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bentz</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Lindaloff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>511-07-2119</u>	
17. INFORMANT <u>Luella Bentz</u> Address <u>52me above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>5810</u> IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage, massive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to esophageal varices, ruptured</u> DUE TO (c) <u>due to cirrhosis, liver</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 6, 1967</u> to <u>Sept 7, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept 7</u> 19 <u>67</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Brewer MD</u>		22b. DATE SIGNED <u>9/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. BREWER</u>		22d. ADDRESS <u>8505 Old Georgetown Road Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK

March 10, 1911

My dear Sir:

I have the honor to acknowledge the receipt of your letter of the 2nd inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours truly,
W. W. Bentley, Jr.

Very truly yours,
W. W. Bentley, Jr.

Enclosed for you are two copies of the report of the Board of Regents of the State University of New York, dated and captioned as above.

I am, Sir, very respectfully,
Yours truly,
W. W. Bentley, Jr.

Very truly yours,
W. W. Bentley, Jr.

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W. W. Bentley, Jr.

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Yours truly,
W. W. Bentley, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12550

CERTIFICATE OF DEATH

12559

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanatorium		d. STREET ADDRESS 8500 - 16th Street	
3. NAME OF DECEASED (Type or print) First JACK Middle MYER Last BISCARR		4. DATE OF DEATH Month Sept. Day 26 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 August 1902
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Retail Store		10b. KIND OF BUSINESS OR INDUSTRY Shoe	
11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Bisgyer		14. MOTHER'S MAIDEN NAME Violet Rosenblatt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-07-4808A	
17. INFORMANT Donald Biscarr		Address 4118 Havard St., SSpg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Art. Heart Disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1 , 19 65 , to Sept 15 , 19 67 , that (I) (we) last saw the deceased alive on Sept 15 , 19 67 , and that death occurred at 4 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Isidore Shulman M.D.		22b. DATE SIGNED 9-27-67	
22c. PHYSICIAN'S NAME (Type) Isidore Shulman, M.D.		22d. ADDRESS 915 19th Street N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-28-67	
23c. NAME OF CEMETERY OR CREMATORY Natl. Mem. Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Goldberg Funeral Home		25a. REC'D BY REGISTRAR SEP 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

STATE OF TEXAS
COUNTY OF DALLAS

Know all men by these presents, that _____ of the County of _____ State of _____ do hereby certify that _____ of the County of _____ State of _____ is the owner of the following described land, to-wit:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

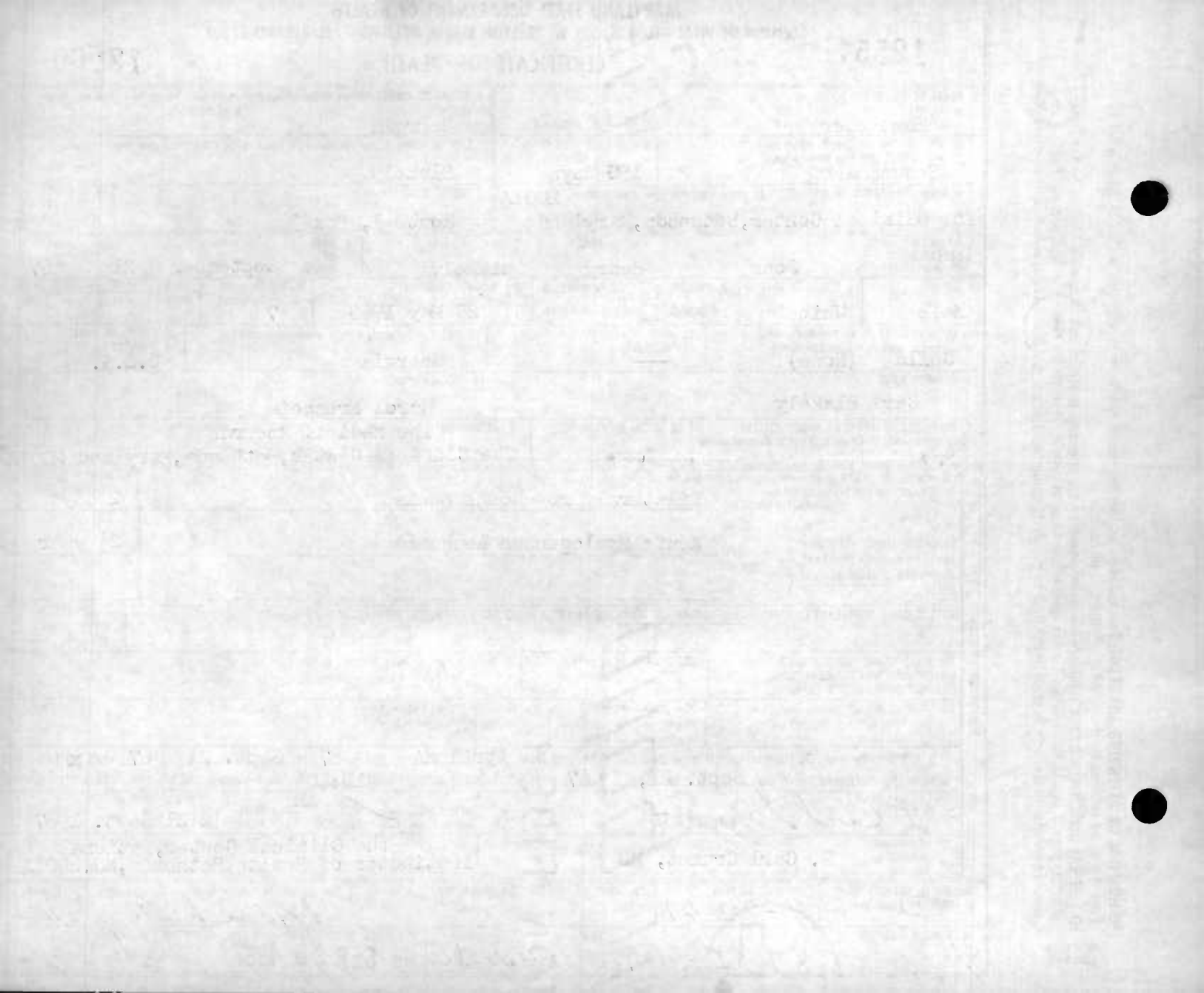
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12551

CERTIFICATE OF DEATH

12560

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Georgia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 150 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blakely 49-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20014 The Clinical Center, Bethesda, Maryland			d. STREET ADDRESS Route 1, Box 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last John Henry Blakely			4. DATE OF DEATH Month Day Year September 21 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 May 1960	9. AGE (In years lost birthday) 7 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child (None)		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Georgia	
13. FATHER'S NAME Carl Blakely			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			14. MOTHER'S MAIDEN NAME Carol Erenheim		
16. SOCIAL SECURITY NO. None			17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland 20014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Myelogenous Leukemia DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 days 2 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from April 24, 19 67, to Sept. 21, 1967, that (X) (we) last saw the deceased alive on Sept. 21, 19 67, and that death occurred at 10:10M, from causes and on the date stated above.					
22a. SIGNATURE F. Carl Grumet		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 21 Sept. 1967	
22c. PHYSICIAN'S NAME (Type) F. Carl Grumet, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9-22-67	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Monrovia, Md.	
24. FUNERAL DIRECTOR Frazier 389 B.F. ...		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 26 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



12552

CERTIFICATE OF DEATH

12561

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where dec. lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d. STREET ADDRESS <u>1000 Narahoe Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Blendman Sarah Ann Blendman</u>		4. DATE OF DEATH Month Day Year <u>9 7 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1914</u>
9. AGE (In years lost birthday) <u>53 yrs.</u>		10. IF UNDER 1 YEAR Months Days <u>9 7</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-48-6198</u>	
17. INFORMANT <u>Mrs. Harold Jaimberg</u>		Address <u>S.S. Md. 1000 Narahoe Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Cardiac Standstill 4 min</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>Acute Coronary Occlusion</u> DUE TO (c) <u>2 days</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension atherosclerosis heart disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/9</u> , 19 <u>67</u> , and that death occurred at <u>2:28</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin Manchester</u> M.D.		22b. DATE SIGNED <u>SEP 11 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN MANCHESTER</u>		22d. ADDRESS <u>3200-16 St N. St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Adas Israel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Donald M. Stein Hebrew Memorial</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Funeral Home</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

UNIVERSITY OF MASSACHUSETTS

3232



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>47 Days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		d. STREET ADDRESS <u>45 South Paula Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edward</u> Last <u>Bly</u>		4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>20 February 1953</u>
9. AGE (In years lost birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Curtis A. Bly</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Souder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Records</u>		<u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pleural Effusion</u> DUE TO (c) <u>Hodgkin's Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>1 month</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia; Herpes Zoster</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>17 July</u> , 19 <u>67</u> , to <u>2 Sept.</u> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2 Sept.</u> , 19 <u>67</u> , and that death occurred at <u>8:55 M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Young</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>2 September 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Young, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Md.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.</u>	

CERTIFICATE OF DEATH

1934

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of undertaker	
13. Signature of funeral home		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of crematorium		18. Signature of cremation		19. Signature of cremation		20. Signature of cremation	
21. Signature of cremation		22. Signature of cremation		23. Signature of cremation		24. Signature of cremation	
25. Signature of cremation		26. Signature of cremation		27. Signature of cremation		28. Signature of cremation	
29. Signature of cremation		30. Signature of cremation		31. Signature of cremation		32. Signature of cremation	
33. Signature of cremation		34. Signature of cremation		35. Signature of cremation		36. Signature of cremation	
37. Signature of cremation		38. Signature of cremation		39. Signature of cremation		40. Signature of cremation	
41. Signature of cremation		42. Signature of cremation		43. Signature of cremation		44. Signature of cremation	
45. Signature of cremation		46. Signature of cremation		47. Signature of cremation		48. Signature of cremation	
49. Signature of cremation		50. Signature of cremation		51. Signature of cremation		52. Signature of cremation	
53. Signature of cremation		54. Signature of cremation		55. Signature of cremation		56. Signature of cremation	
57. Signature of cremation		58. Signature of cremation		59. Signature of cremation		60. Signature of cremation	
61. Signature of cremation		62. Signature of cremation		63. Signature of cremation		64. Signature of cremation	
65. Signature of cremation		66. Signature of cremation		67. Signature of cremation		68. Signature of cremation	
69. Signature of cremation		70. Signature of cremation		71. Signature of cremation		72. Signature of cremation	
73. Signature of cremation		74. Signature of cremation		75. Signature of cremation		76. Signature of cremation	
77. Signature of cremation		78. Signature of cremation		79. Signature of cremation		80. Signature of cremation	
81. Signature of cremation		82. Signature of cremation		83. Signature of cremation		84. Signature of cremation	
85. Signature of cremation		86. Signature of cremation		87. Signature of cremation		88. Signature of cremation	
89. Signature of cremation		90. Signature of cremation		91. Signature of cremation		92. Signature of cremation	
93. Signature of cremation		94. Signature of cremation		95. Signature of cremation		96. Signature of cremation	
97. Signature of cremation		98. Signature of cremation		99. Signature of cremation		100. Signature of cremation	



ORIGINAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #7 Film #G383 9/27/67 ph											
12554											
12563											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Wayne</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waymart</u> <u>75.3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u> <u>20014</u>						d. STREET ADDRESS <u>Box 16</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>Emory</u> Last <u>Bond</u>						4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>August 12, 1908</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard: Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Myron Bond</u>						14. MOTHER'S MAIDEN NAME <u>Edith Emory</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>211-12-1035</u>		17. INFORMANT <u>The Medical Records</u> <u>20014</u> <u>The Clinical Center, Bethesda, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Bone Marrow Aplasia</u> DUE TO (c) <u>Macroglobulinemic Lymphoma</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 days</u> <u>4 years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>20</u>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 12 1967</u> , to <u>September 19 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 20 1967</u> , and that death occurred at <u>2:30 M.</u> from causes and on the date stated above.											
22a. SIGNATURE <u>Donald N. Buell MD</u>						PM ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>20 Sept. 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Donald N. Buell, M. D.</u>						22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept. 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Laanan Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>Laanan Township, Pa.</u>			
24. FUNERAL DIRECTOR <u>Katherine A. Humphrey</u>						ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

12555		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		12564	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		<u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dubucon</u>				d. STREET ADDRESS <u>901 Wade Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Solomon</u> Middle <u>Victor</u> Last <u>Booner</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 24 - 1888</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Seymour</u>				14. MOTHER'S MAIDEN NAME <u>Makala</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daughter</u> <u>Kate Sommers (same as above)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Dehydration & gangrene both legs</u> DUE TO (c) <u>Arteriosclerosis & thrombosis of arteries causing post-operative gangrene</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Rheumatic heart disease & fibrillation. History of strokes</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> , 19 <u>67</u> , to <u>9/19</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9/19</u> , 19 <u>67</u> , and that death occurred at <u>1:30 P</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>J. R. Thistlethwaite</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. R. Thistlethwaite</u>				22d. ADDRESS <u>1746 K St. N. W. Wash, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Buena</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederick, W. Va.</u>	
24. FUNERAL DIRECTOR <u>Sydney Wheeler F. H. Rockville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF HEATH

MADE IN THE UNITED STATES OF AMERICA

MADE IN THE UNITED STATES OF AMERICA

1951



5 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12556

12565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4610 Chestnut St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ADOLPH</u> First <u>Harry</u> Middle <u>Borjes</u> Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 29, 1883</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>Sept 29</u> 19 <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Borjes</u>		14. MOTHER'S MAIDEN NAME <u>Christine Elsenheimer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Tebbetts C. Borjes, Wife, Same as</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>16 Sept 1967</u> to <u>30 Sept 1967</u> that (I) (we) last saw the deceased alive on <u>29 Sept 1967</u> and that death occurred <u>9/29/67</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Herbert Martyn</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>30 Sept 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>		22d. ADDRESS <u>4740 Chevy Chase Dr.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>10/2/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, 5130 Wis. Ave. NW, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

THE STATE OF TEXAS

July 2, 1933

U.S. Court

County of Tarrant

State of Texas

Tracy, John W. vs. The State of Texas

Plaintiff

vs.

Defendant

1

John W. Tracy, Plaintiff

vs. The State of Texas, Defendant

1933

July 2

1933

12557

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12566

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>16 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 SILVER SPRING AVENUE, MD.</u>				d. STREET ADDRESS <u>710 SILVER SPRING AVENUE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>HALE</u> Last <u>BOWMAN</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 19, 1887</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Construction</u>			
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>SAMUEL BANKS BOWMAN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH DICKENS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217 091364 A</u>			
17. INFORMANT <u>MRS. TRUDA BARNES</u>				Address <u>AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF URINARY BLADDER</u> <u>1810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>WITH LOCAL METASTASIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) (County) (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> 19 <u>59</u> , to <u>SEPT. 2</u> 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>SEPT. 2</u> 19 <u>67</u> , and that death occurred at <u>845</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>James A. Roberts</u>				22b. DATE SIGNED <u>SEPT. 2, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				22d. ADDRESS <u>8907 GEORGIA AVE. SILVER SPRING, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Sept. 6, 1967</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln</u>				23d. LOCATION (City, town, or county) (State) <u>Prince George County Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

1

CHINA

12558

CERTIFICATE OF DEATH

12567

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp LeJuene	
c. LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS MOQ 2102 MCB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Terrill Last BRAY		4. DATE OF DEATH Month September Day 28 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1916
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Oak Park, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William John Bray		14. MOTHER'S MAIDEN NAME Louise Terrill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941-1967		16. SOCIAL SECURITY NO. 348 01 0974	
17. INFORMANT Camp LeJuene, North Carolina		Mrs. Harriet Bray, MOQ 2102, MCB	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0 DUE TO Lymphatic Chronic Lymphatic/Leukemia with bilateral bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 21, 1967 , to Sept. 28, 1967 , that (X) (we) last saw the deceased alive on Sept. 28, 1967 , and that death occurred at 655P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>David R. Foreman</i>		22b. DATE SIGNED Sept. 29, 1967	
22c. PHYSICIAN'S NAME (Type) Daivid R. Foreman, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/3/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR FallsChurch Funeral Home		25a. REC'D BY REGISTRAR W. J. M. [Signature]	
1102 West Broad Street, Falls Church, Va.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12553

12568

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 7 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 69 Montgomery County General Hospital		e. STREET ADDRESS 9020 Fairfield Road	
3. NAME OF DECEASED (Type or print) First Middle Last HANNAH MARY BROOME		4. DATE OF DEATH Month Day Year Sept. 11, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1886
9. AGE (In years lost birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Camden, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Dr. Charles C. Jones		14. MOTHER'S MAIDEN NAME Lillie Moreatt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-44-1448	
17. INFORMANT Daughter		Address Eleanor Broome	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left DUE TO breast with generalized DUE TO metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 1964 to 9/11, 1967 , that (I) (we) last saw the deceased alive on 9/11, 1967 , and that death occurred at 6:30 PM from causes and on the date stated above.			
22a. SIGNATURE Arthur F. Woodward		22b. DATESIGNED 9/12/67	
22c. PHYSICIAN'S NAME (Type) ARTHUR F. WOODWARD		22d. ADDRESS 115 N. VanBuren Street Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-13-67	23c. NAME OF CEMETERY OR CREMATORY Darnestown Presby. Cem.	23d. LOCATION (City or Town) (County) (State) Darnestown, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR SEP 14 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

RECEIVED BY THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

1918

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

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1 M

1

2

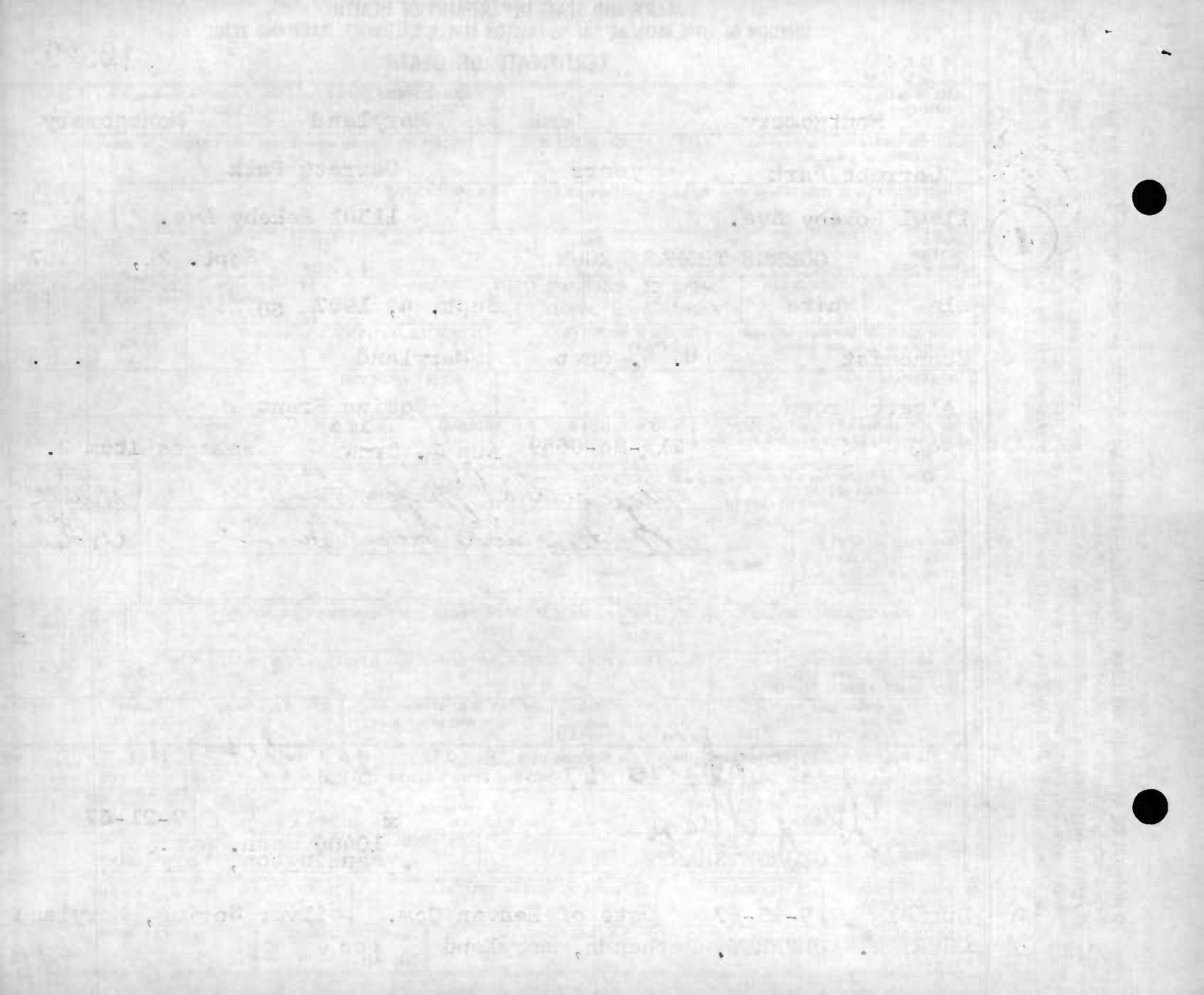
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

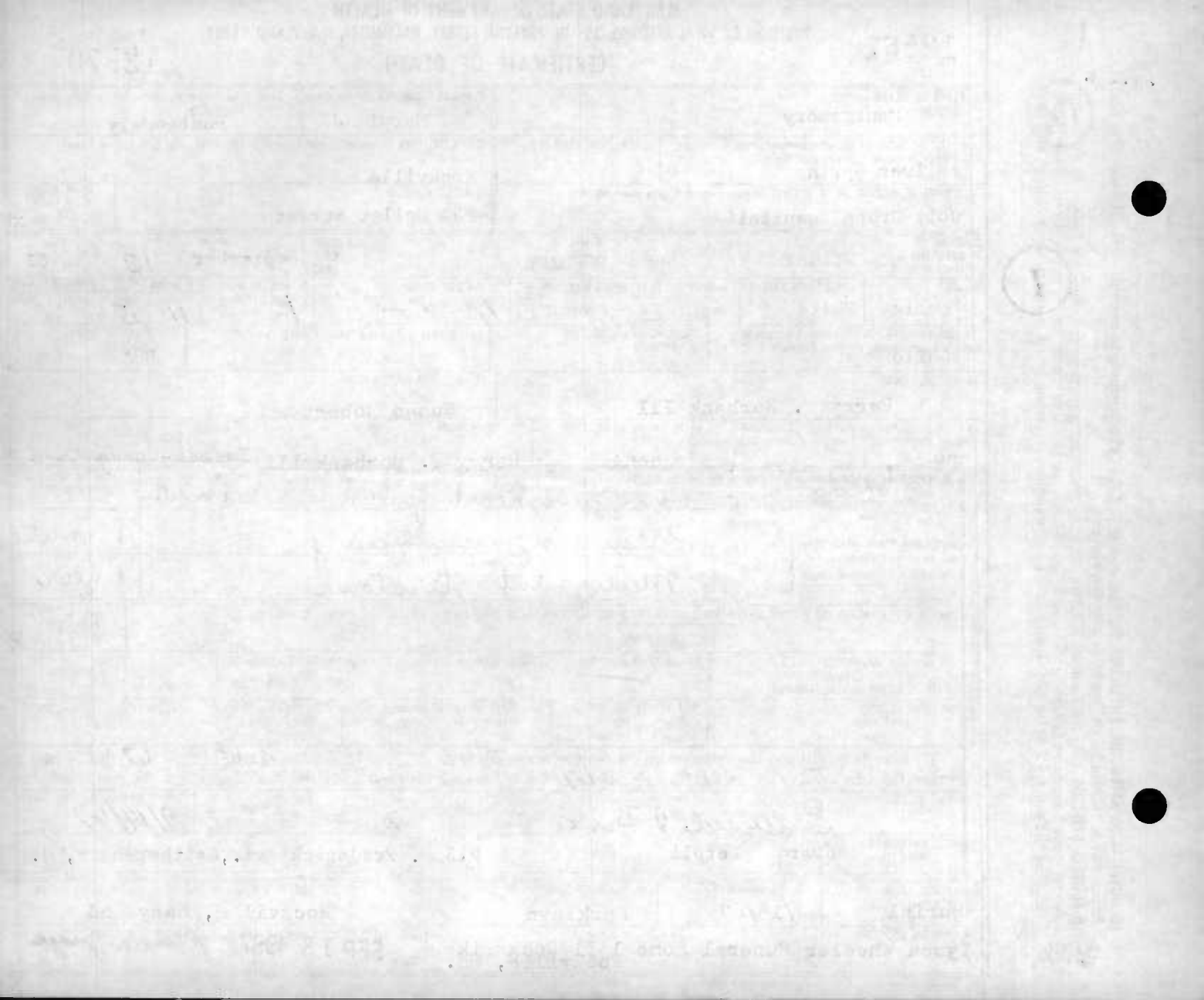
CERTIFICATE OF DEATH

12569

12560

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11301 Rokeby Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GOERGE THOMAS BROWN		4. DATE OF DEATH Month Sept. Day 21 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1907
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Albert Brown		14. MOTHER'S MAIDEN NAME Rosina Franz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-26-0659	
17. INFORMANT Wife		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Ante-mortem Heart Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Months years Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-26 , 19 63 , to Sept 21 , 19 67 , that (I) (we) last saw the deceased alive on Sept 20 , 19 67 , and that death occurred at 6:04 A.M. , from causes and on the date stated above.			
22a. SIGNATURE George Sharpe		22b. DATE SIGNED 9-21-67	
22c. PHYSICIAN'S NAME (Type) GEORGE SHARPE		22d. ADDRESS 10400 Conn. Ave. Kensington, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-23-67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE SEP 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	





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Cleared for release by Dr. Reap, Medical Examiner

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb D.O.A.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery Gen. Hospital		d. STREET ADDRESS 27129 Ridge Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Paul NMN Burner		4. DATE OF DEATH Month September Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/2/97
9. AGE (In years lost birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Mont. Cty. Roads	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur B. Burner		14. MOTHER'S MAIDEN NAME Otta Smoot	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-286537	
17. INFORMANT Medical Records -		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from 10/18 , 19 65 , to 9/22 , 19 67 , that (I) was last saw the deceased alive on 9/22 , 19 67 , and that death occurred at 9/22 , 19 67 , at 9/22 M, from causes and on the date stated above.			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 9/23/67	
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		22d. ADDRESS Ridge Road, Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-25-67	
23c. NAME OF CEMETERY OR CREMATORY Damascus		23d. LOCATION (City or Town) (County) (State) Damascus Mont. Md.	
24. FUNERAL DIRECTOR Francis H. Barber		25a. REC'D BY REGISTRAR Laytonsville, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 26 1967	

ENDING LISTED (FROM 10 AND 01) LISTED BELOW

Francis H. Barber
Latona, Md.
2-25-07
DANVERS

DANVERS, NORT. MD.
Middle Road, Danvers, Md.

CERTIFICATE OF DEATH

Reg. Dist. No.

12563

12572

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>XXXX Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>			
c. LENGTH OF STAY IN 1b <i>4 years</i>				d. STREET ADDRESS <i>7002 Lovell Drive</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>90 Althea Woodland Nursing Home 1000 Daleview Dr.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>Ethel</i> Last <i>Burton</i>				4. DATE OF DEATH Month <i>September</i> Day <i>1</i> Year <i>19 67</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 17, 1884</i>	
9. AGE (In years lost birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>1</i> Hours <i>19</i> Min.		IF UNDER 24 HRS. Hours <i>19</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Owner</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Florist & Nurseries</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>William T. Gessford</i>				14. MOTHER'S MAIDEN NAME <i>Ida Shepperson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>214-32-8226 A</i>			
17. INFORMANT <i>William G. Burton</i>				Address <i>7002 Lovell Dr. Hyattsville</i>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Generalized arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 years</i> <i>15 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>1950</i> , 19 to <i>9-1</i> , 1967 that I last saw the deceased alive on <i>9-1</i> , 1967, and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>1835 1st NW. Wash DC 20006</i>							
DATE SIGNED <i>9-1-67</i>							
ACTUAL SIGNATURE <i>James J. Burns</i> M.D.							
PHYSICIAN'S NAME (Type) <i>JAMES T. BURNS M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>							
22b. DATE THEREOF <i>Sept. 5, 1967</i>							
22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>							
22d. LOCATION (City, town, or county) (State) <i>P.G. co. Maryland</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. Glen Carter</i> ADDRESS <i>Wanner E. Pumphrey Inc. 8434 Georgia Ave S.S. Md.</i>							
24a. REC'D BY REGISTRAR <i>SEP 8 1967</i>							
24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1* and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Decedent

Married

Residence

Place of Birth

Age

Date of Death

Time of Death

Place of Death

Sex

Color

Height

Weight

Build

Complexion

Education

Occupation

Religion

Marital Status

Cause of Death

Immediate Cause of Death

Underlying Cause of Death

Contributing Cause of Death

Manner of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Witness

Signature of Family

Signature of Neighbor

Signature of Minister

Signature of Justice

Signature of Sheriff

Signature of Constable

Signature of Undertaker

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

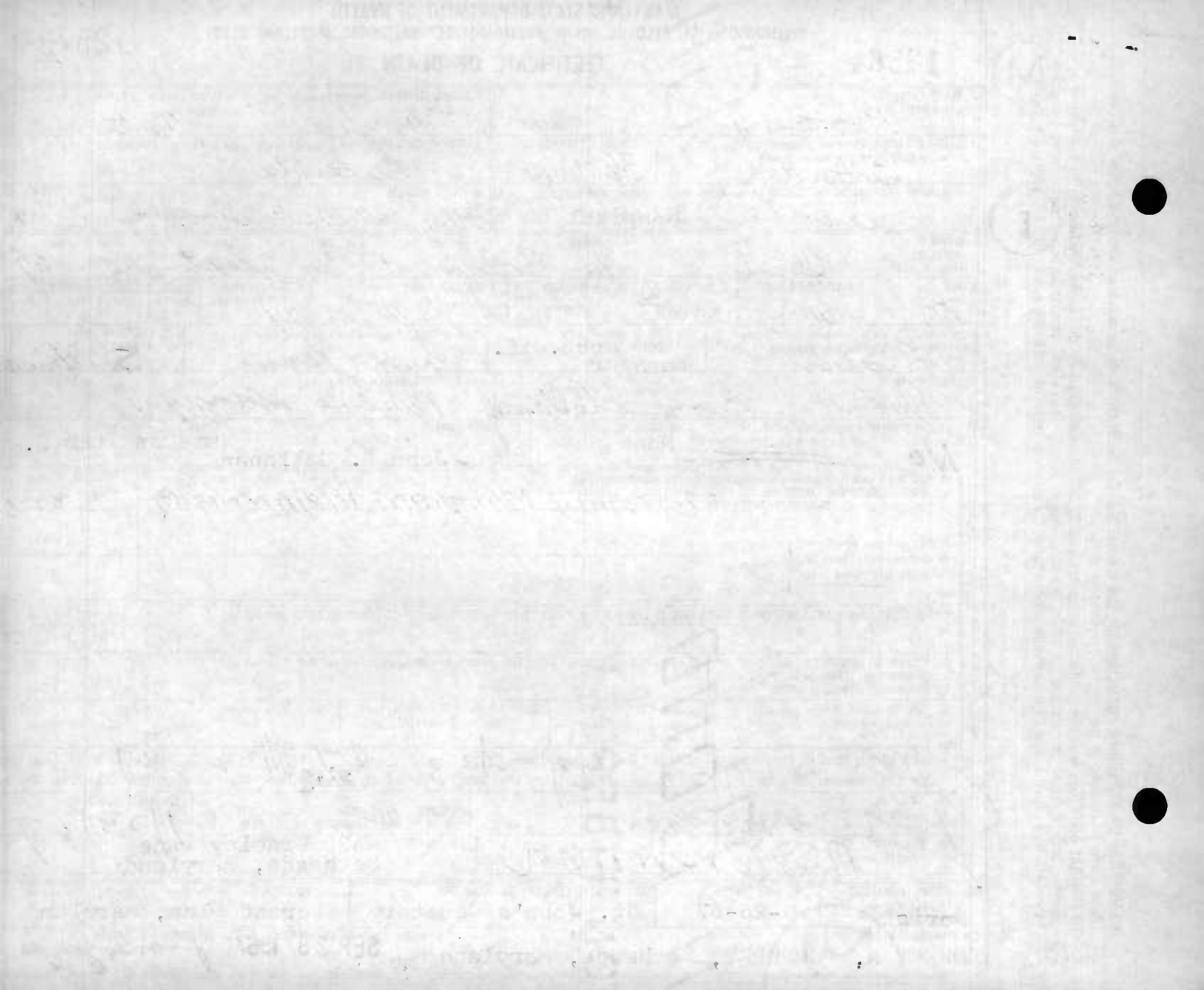
12573

12564

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>36 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4401 East West Hwy Apt 402</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cecil X. Callanan</u>		4. DATE OF DEATH Month Day Year <u>Sept - 23 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/6/1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Acct. Off. Manager</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>South Africa</u>		12. CITIZEN OF WHAT COUNTRY? <u>So Africa</u>	
13. FATHER'S NAME <u>John Bernard Callanan</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Sangig</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John - John P. Callanan</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Malignant Melanoma</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>67</u> , to <u>9/22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9/22</u> 19 <u>67</u> , and that death occurred at <u>9/23</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A.J. Brennan</u>		22b. DATE SIGNED <u>9/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.J. Brennan</u>		22d. ADDRESS <u>4429 Bradley Lane Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Forest Glen, Maryland</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 29 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12574

12565

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day 2 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlesburg</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Route # 1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frances E. Calloway</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/67</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Hedgecock</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Strong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-40-2866</u>	
17. INFORMANT <u>Edward Calloway</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BronchoPneumonia</u> DUE TO (b) <u>Adenocarcinoma of Colon with metastasis</u> DUE TO (c) <u>3 yr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>9/22/67</u>	
EXAMINER'S NAME (Type) <u>Dr. John G. Ball</u> M.D.		Address (Street, city, town, or county) <u>Montgomery Co., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 25, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert E. Dailey & Son</u>		25a. REC'D BY REGISTRAR <u>SEP 26 1967</u>	
ADDRESS <u>Frederick, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2d Film #G392 9/20/67

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa</u>				d. STREET ADDRESS <u>218 Shaw Ave</u> <u>12135 1/2 New Highway Blvd Ave</u>		15.1	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>A.</u> Last <u>Campbell</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1888</u>	9. AGE (In years lost birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel T. Addison</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Micou</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Addison Campbell</u> Address <u>Hastings, N.Y.</u> <u>174 Villard Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>410X</u> IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Cong Heart Failure</u> DUE TO (c) <u>Mitral Stenosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years</u> <u>50 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-2</u> , 19 <u>66</u> , to <u>9-10</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9-9</u> 19 <u>67</u> , and that death occurred at <u>6:50</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>R. H. Sandstrom</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom</u>				22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>William J. Zickner & Sons North & Pades</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF TEXAS
COUNTY OF DALLAS

Know all men by these presents, that

JOHN A. SMITH

of the County of Dallas, State of Texas, for and in consideration of the sum of

One Hundred Dollars (\$100.00), to him in hand paid by

JOHN A. SMITH

the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said

JOHN A. SMITH

JOHN A. SMITH

JOHN A. SMITH

JOHN A. SMITH

JOHN A. SMITH

Witness my hand and seal this

day of

19

at Dallas, Texas.

JOHN A. SMITH

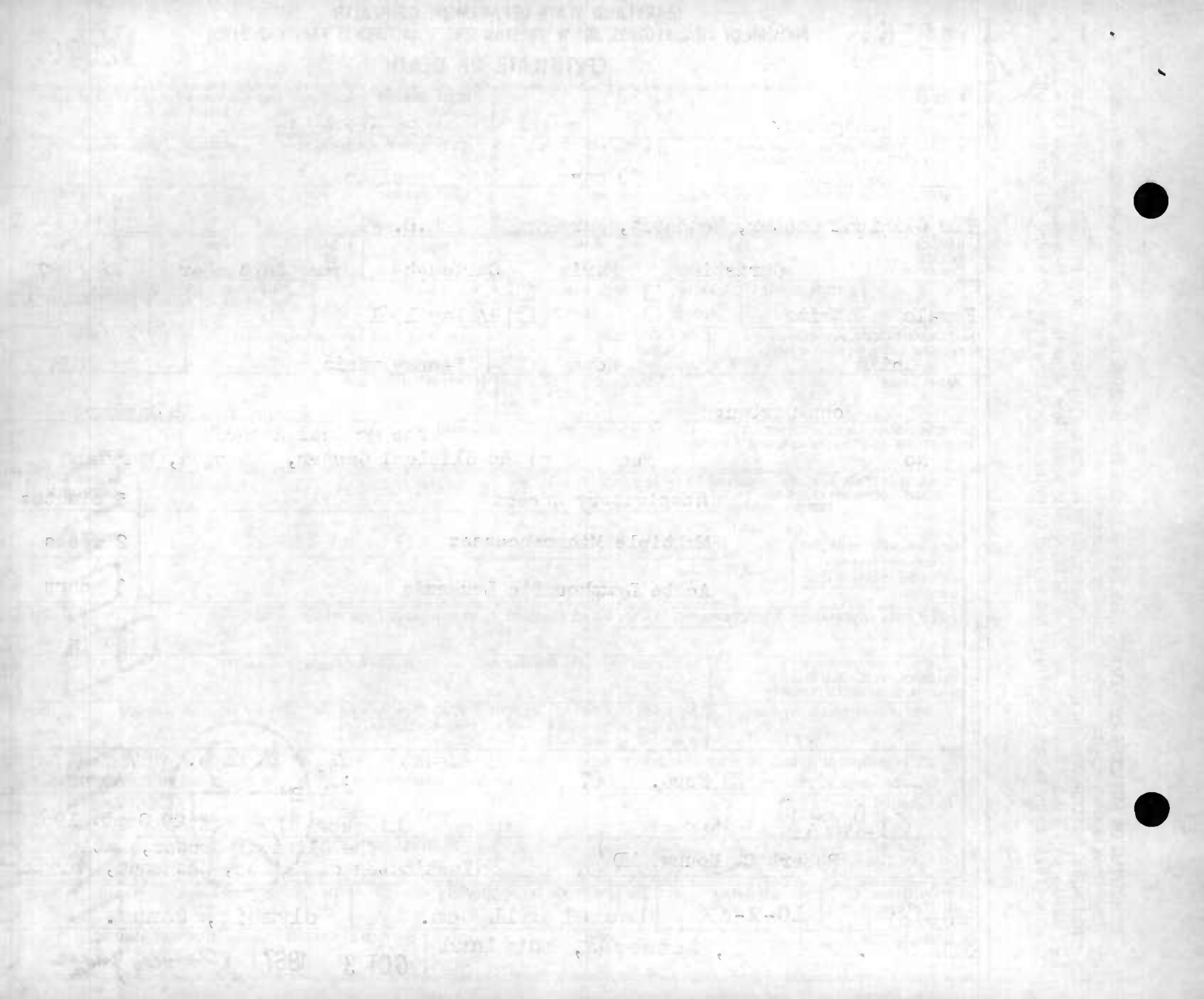
CERTIFICATE OF DEATH

12576

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Hellam</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>50 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hellam</u> <u>75, 3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>R.D. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Christine</u> Middle <u>Marie</u> Last <u>Carbaugh</u>				4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 May 1961</u>		9. AGE (In years last birthday) <u>6</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Carbaugh</u>				14. MOTHER'S MAIDEN NAME <u>JoAnn Van Valkenburgh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO (b) <u>Multiple Microabscesses</u> DUE TO (c) <u>Acute Lymphocytic Leukemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>2 weeks</u> <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9 August, 1967</u> , to <u>28 Sept., 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>28 Sept., 1967</u> , and that death occurred at <u>9:55 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Young</u>				M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>29 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Young, MD</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Columbia, Penna.</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



12577

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

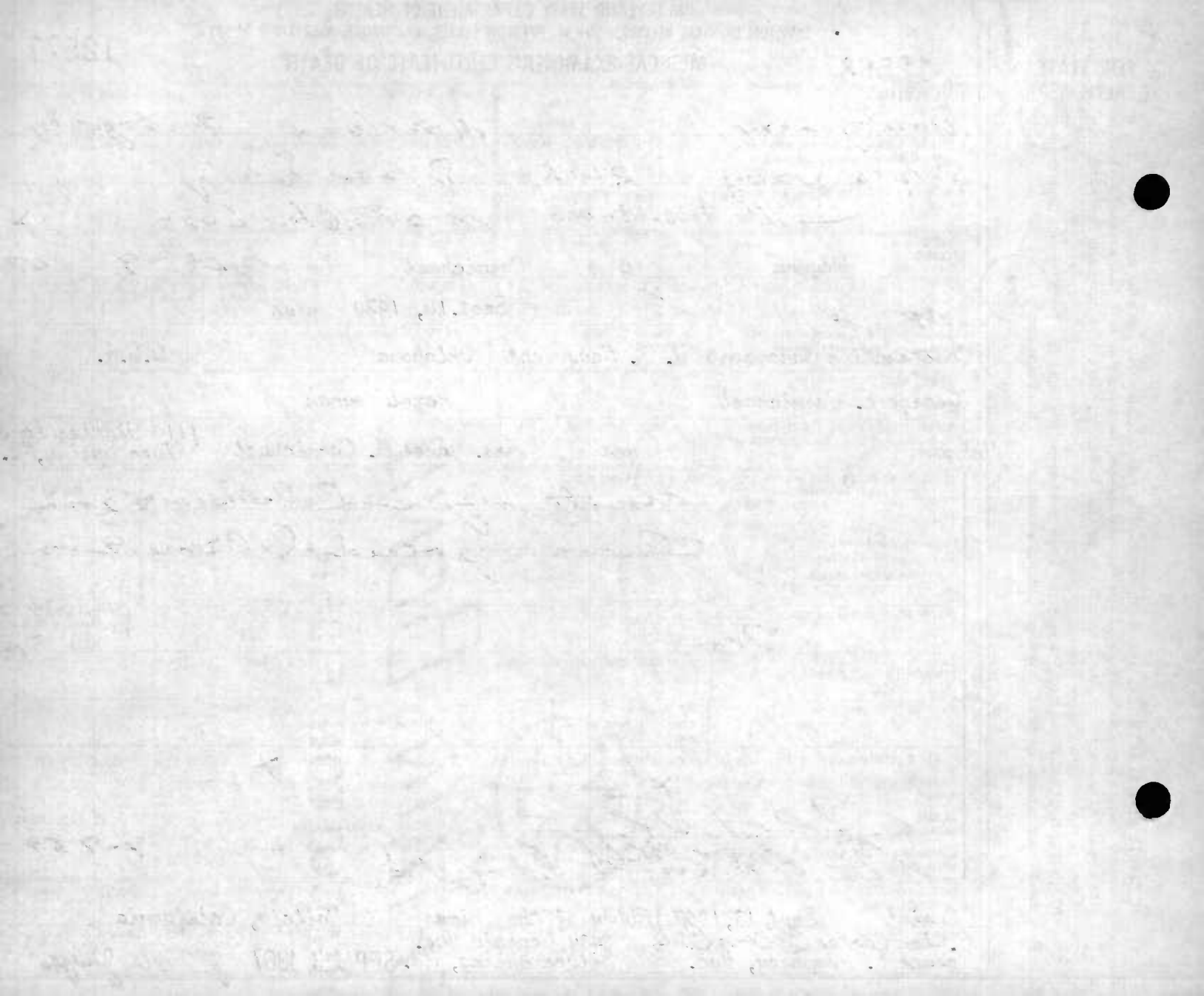
12568

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>2 wks</u>		d. STREET ADDRESS <u>1110 Fiddler Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1110 Fiddler Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wayman D Carmichael</u>		4. DATE OF DEATH <u>Sept. 9</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Management</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy Dept</u>	9. AGE (In years last birthday) <u>46</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George E. Carmichael</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Wayman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mrs. Janet M. Carmichael</u>		Address <u>1110 Fiddler Lane Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO (b) <u>Chronic myocardial disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Underdetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John L. Rogers</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John L. Rogers, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Abbey of the Chimes</u>		23d. LOCATION (City or Town) (County) (State) <u>Vallejo, California</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
Address <u>254 Georgia Ave Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



12569

12578

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley Chase</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8804 Walnut Hill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Louise W. Chase</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pittsburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh H. Weedon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Lipscombe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>377-01-33250</u>	
17. INFORMANT <u>Brother - Sidney Weedon</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obstructive pulmonary disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> , 19 <u>64</u> to <u>present</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept. 20 1967</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John B. Umhau</u>		22b. DATE SIGNED <u>9/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU</u>		22d. ADDRESS <u>8805 Conq. Ave. Ch. Co. Md</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>	23b. DATE THEREOF <u>9-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Suitland Md Prince Geo</u>
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>7557 Wisconsin Ave Bethesda Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

IN WITNESS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland		b. COUNTY		Montg,					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				Gaithersburg		c. LENGTH OF STAY IN lb				37 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Gaithersburg				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS				7 Chestnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH	Month	Day	Year		
Eugenia			Athelia			Childers						Sept	4th	1967			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov 30th 1902		64 yrs		Months		Days		Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
House Wife				" "				Elkins. W. Va				U S A					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME											
Eugene D. Liller						Lillian E. Simms											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
				218-20-2430				Kathleen E. Hanna				Gaithersburg, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												2 days					
DUE TO																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												3 yrs					
DUE TO																	
(c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)																	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)					
Month, Day, Year				While <input type="checkbox"/> Not While <input type="checkbox"/>								(County)					
Hour a.m.				at work <input type="checkbox"/> at work <input type="checkbox"/>								(State)					
p.m.				19													
21. I certify that (I) (his hospital) attended the deceased from 1/30 to 9/4, 1967, that (I) (we) saw the deceased alive on 9/4, 1967, and that death occurred at 3:50 A.M. from the causes and on the date stated above.																	
22a. SIGNATURE								22b. DATE				SIGNED					
Melvin J. Kordon								M.D.									
22c. PHYSICIAN'S NAME (Type)								22d. ADDRESS									
Melvin J. Kordon MD								13 Deer Park Drive Gaithersburg Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county)					
Burial				9-6-67				Park Lawn				Rockville, Md.					
24 FUNERAL DIRECTOR'S SIGNATURE								25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Ernest C. Garther								Gaithersburg, Md.				SEP 7 1967					

(183)

CERTIFICATE OF DEATH

1832

THE STATE OF NEW YORK

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to棺 papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 9 d.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY 483 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lake Worth d. STREET ADDRESS 230 North B Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle Maud Last Chilson		4. DATE OF DEATH Month Sept. Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1885 9. AGE (In years lost birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? Amer.	
13. FATHER'S NAME Robinson		14. MOTHER'S MAIDEN NAME Not available	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 014 20 0586 B	
17. INFORMANT Hosp. Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Intestinal Obstruction DUE TO (c) Adhesions		INTERVAL BETWEEN ONSET AND DEATH 9 days Into 9 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Age - Old		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 4, 1967 , to Sept 13, 1967 , that (I) (not) lost saw the deceased alive on Sept 12, 1967 , and that death occurred at 4 A.M. from causes and on the date stated above.			
22a. SIGNATURE W.W. Eastman		22b. DATE SIGNED Sept 13 1967	
22c. PHYSICIAN'S NAME (Type) W.W. EASTMAN		22d. ADDRESS 831 University Blvd E Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 15, 1967	Fort Lincoln Cemetery	Calver Manor Pk. Md
24. FUNERAL DIRECTOR J. Arthur Walter		25a. RECEIVED BY REGISTRAR 254 Carroll St NW Washington D.C.	
25b. REGISTRAR'S SIGNATURE J. Arthur Walter		DATE SEP 18 1967	

STATE OF NEW YORK

Albany

January 10, 1901

Dear Sir:

I have

the honor to

acknowledge the receipt of your

letter of the 8th inst.

relative to

the matter

of the

same, and in reply to

advise you that

the same has

been forwarded

to the

proper authorities

for their consideration.

I am

very respectfully

Yours very truly,

Wm. W. Aldrich

Secretary of the Treasury

Very truly yours,

Wm. W. Aldrich

Secretary of the Treasury

Enclosed for you are

two copies of

the report of the

Commissioner of the

Internal Revenue

Service for the

year ending June 30,

1900.

Very truly yours,

Wm. W. Aldrich

Secretary of the Treasury

Enclosed for you are

two copies of the

report of the

Commissioner of the

Internal Revenue

Service for the

year ending June 30,

1900.

Very truly yours,

Wm. W. Aldrich

Secretary of the Treasury

Enclosed for you are

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12572
CERTIFICATE OF DEATH
12581

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 514 Deerfield Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 514 Deerfield Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle CHOPNICK Last CHOPNICK		4. DATE OF DEATH Month Sept. Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?? 1897
9. AGE (in years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Retailer		10b. KIND OF BUSINESS OR INDUSTRY Furniture	
11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Aaron Chopnick		14. MOTHER'S MAIDEN NAME Sadie Snider	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. INFORMANT Morris Miller		Address 509 Mansfield Rd, SSpG, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with metastases 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January, 1967 to September 27, 1967 , that (I) (we) last saw the deceased alive on Sept 26, 1967 , and that death occurred at 12:00 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Blaine H. Eig		22b. DATE SIGNED Sept 28, 1967	
22c. PHYSICIAN'S NAME (Type) BLAINE H. EIG		22d. ADDRESS 2641 Coleridge Rd Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Natl. Mem. Park		23d. LOCATION (City, town or county) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217 9th Street N.W.	
25a. REC'D BY REGISTRAR OCT 3 1967		25b. REGISTRAR'S SIGNATURE Johnas Judge	

9254

12573

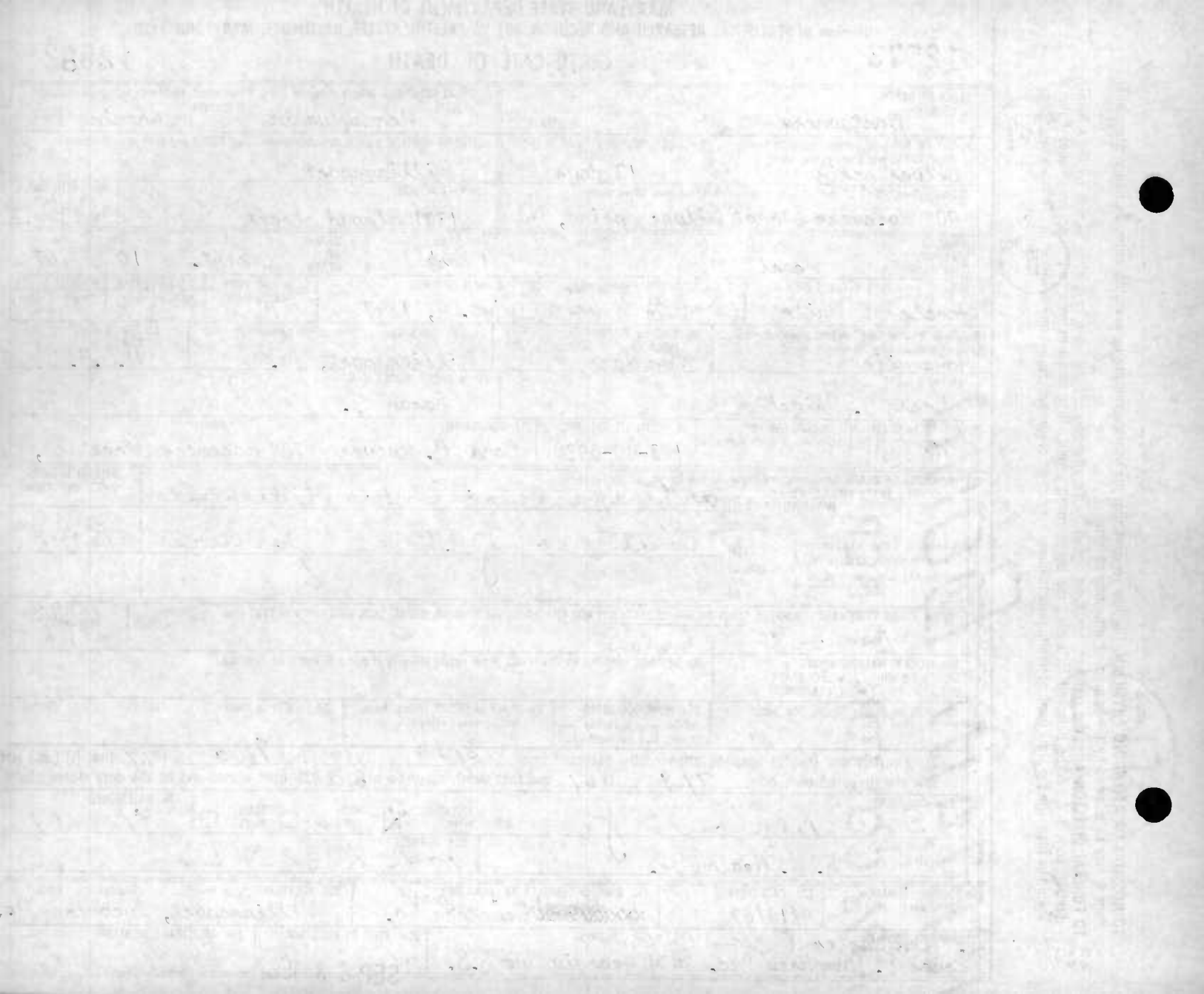
CERTIFICATE OF DEATH

12582

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Lycoming</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> 753	
c. LENGTH OF STAY IN lb <u>12 days</u>		d. STREET ADDRESS <u>1391 Almond Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>708 Rosemere Street Silver Spring, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Clark</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1897</u>
9. AGE (In years last birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse J. Duigel</u>		14. MOTHER'S MAIDEN NAME <u>Sarah J.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>183-40-6930</u>	
17. INFORMANT <u>John C. Hoover</u>		Address <u>708 Rosemere Street SS, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>with congestive failure</u> DUE TO (c) <u>3 mo.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duverticulitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/29</u> , 19 <u>67</u> , to <u>9/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> , 19 <u>67</u> , and that death occurred at <u>8:54</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>S. W. Nealon Jr.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/10/67</u>
22c. PHYSICIAN'S NAME (Type) <u>S. W. Nealon Jr.</u>		22d. ADDRESS <u>1746 K St N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Pleasant Cemetery Co.</u>	23d. LOCATION (City or Town) (County) (State) <u>Williamsport, Lycoming Pa.</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter C. Glen Carter</u> <u>Warner E. Pumphrey Inc. 8434 Georgia Ave S.S.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

12583

12574

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN TB <u>20 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		131	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		d. STREET ADDRESS <u>1001 WADE AVE</u>	
3. NAME OF DECEASED (Type or print) <u>Thelma A. CLARK</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/15</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Aaron Mills</u>		14. MOTHER'S MAIDEN NAME <u>Minnie J. Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Husband</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perudent Lobular Pneumonia</u> DUE TO (b) <u>Bronchogenic Carcinoma; Right Lung</u> DUE TO (c) <u>1621</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/11/1967</u> to <u>9/25/1967</u> , that (I) (we) last saw the deceased alive on <u>9/25/1967</u> and that death occurred at <u>5:50 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen D. Jones</u>		22b. DATE SIGNED <u>9/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN D. JONES</u>		22d. ADDRESS <u>809 Viers Mills Rd. Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF DEATH

1901

Clark

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12575

12584

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>620 Sligo Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Eugene W. CLARKE</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1873</u>
9a. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Coakey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-54-8824</u>	
17. INFORMANT Address <u> </u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease failure</u> DUE TO <u>congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u> </u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Upper Respiratory infection & bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (1) (this hospital) attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>August</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>Aug 1</u> , 19 <u>67</u> , and that death occurred at <u>3:37</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>James R. Coleman MD</u>		22b. DATE SIGNED <u>9/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>SEPT. 23-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FAMILY</u>		23d. LOCATION (City or Town) (County) (State) <u>NINDE King George, Va</u>	
24. FUNERAL DIRECTOR <u>Clifford B. Redding</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 22 1967</u>	

MEDICAL CERTIFICATION

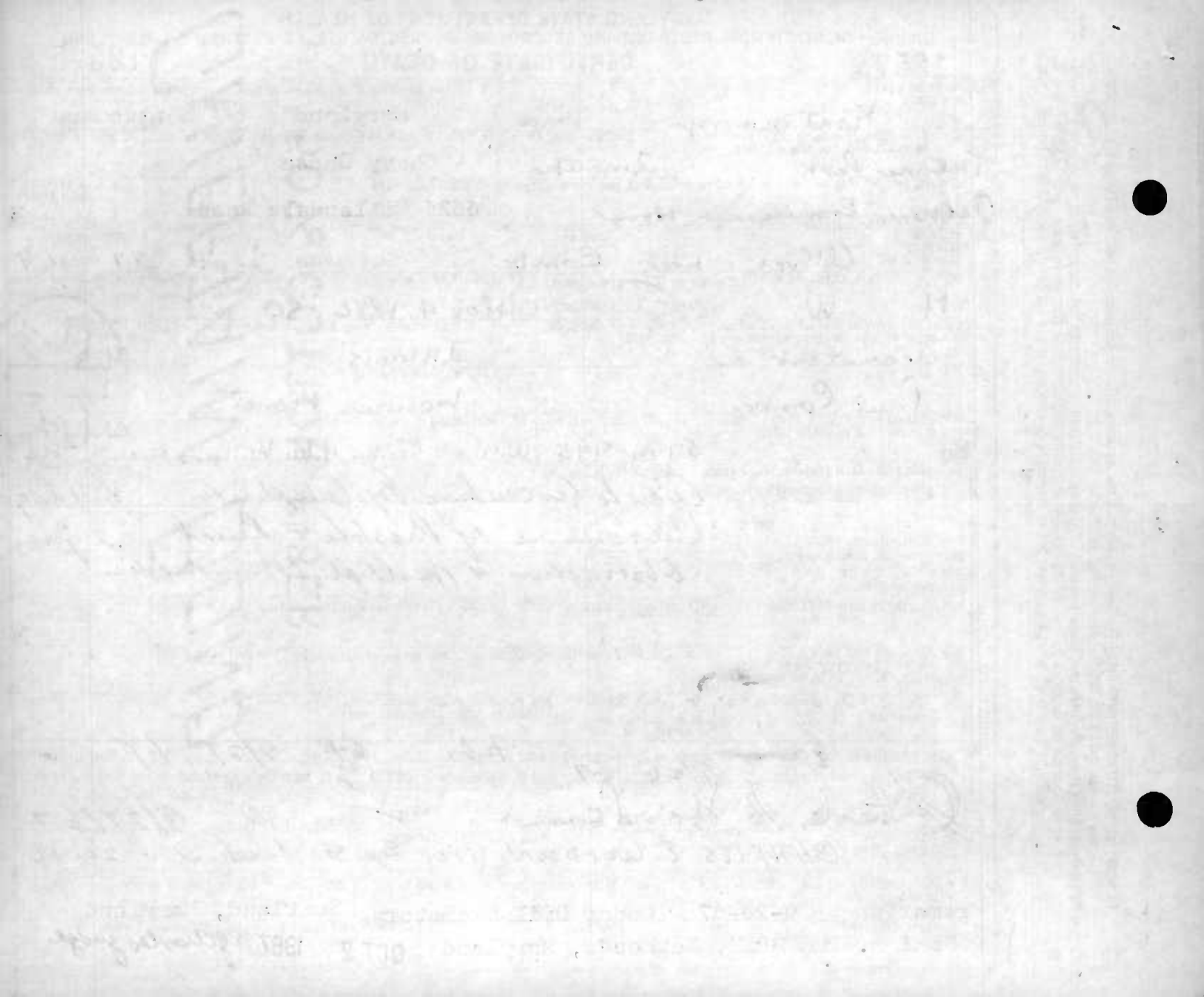
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STATE

PAID TO THE
STATE OF NEW YORK
FOR THE
FISCAL YEAR
ENDING
JUNE 30 1896
THE
TREASURER
OF THE
STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>										
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN 1b <i>2 months</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>90 Oakview Convalescent Home</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chevy Chase</i> d. STREET ADDRESS <i>6625 Hillandale Road</i>					
3. NAME OF DECEASED (Type or print) <i>Alfred Lee Combe</i> First Middle Last			4. DATE OF DEATH <i>Sept. 27 1967</i> Month Day Year		5. SEX <i>M</i> 6. COLOR OR RACE <i>W.</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Nov. 4, 1886</i> 9. AGE (In years last birthday) <i>80</i> yrs. IF UNDER 1 YEAR: Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accountant</i> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <i>Illinois</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			13. FATHER'S NAME <i>Paul Combe</i> 14. MOTHER'S MAIDEN NAME <i>Louise Monet</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i>531-61-5145</i> 17. INFORMANT <i>William Combe</i> Address <i>4701 Willard Ave. Chevy Chase Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Ascending Pyelonephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Carcinoma of Prostate & Renal Obstruction & Multiple osseous Metastases</i> DUE TO (b) <i>2 years</i> DUE TO (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <i>Dr. (this hospital)</i> <i>attended the deceased from Feb. 1967, to 9/27, 1967, that (I) (we) last saw the deceased alive on 9/26 1967, and that death occurred at 8:27 A.M., from the causes and on the date stated above.</i>										
22a. SIGNATURE <i>Charles E. Woodson M.D.</i>					22b. DATE SIGNED <i>9/27/67</i>		22c. PHYSICIAN'S NAME (Type) <i>CHARLES E. WOODSON</i> 22d. ADDRESS <i>1801 Eye St. Wash. D.C. 20006</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>9-28-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>			23d. LOCATION (City, town or county) (State) <i>Suitland, Maryland</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> ADDRESS					25a. REC'D BY REGISTRAR <i>OCT 2 1967</i>		25b. REGISTRAR'S SIGNATURE <i>g Charles Judge</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

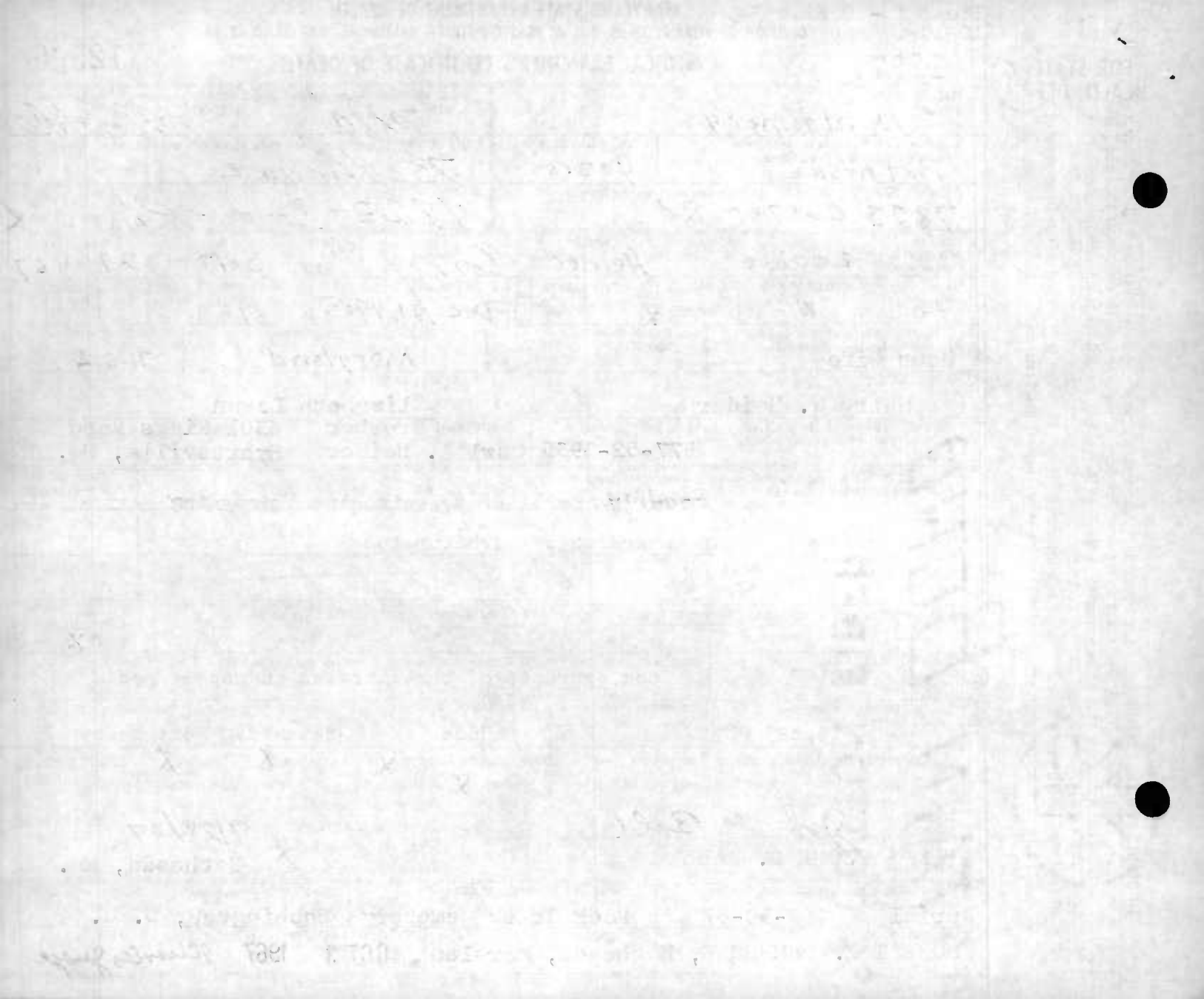
VR A15ME (5)
6M 1/67

Items 18-20 Film 393
10-10-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12586

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN lb <u>years.</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7823 Custer Rd.</u>		d. STREET ADDRESS <u>7823-Custer Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Louise</u> First <u>Heider</u> Middle <u>Corry</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 21, 1905</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry W. Heider</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dernn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-52-3935</u>	
17. INFORMANT <u>Brother</u>		<u>6301 Riggs Road</u> <u>Hyattsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>975x</u> <u>Barbiturate poisoning & drowning</u> DUE TO (b) <u>Overdose of barbiturates</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Took overdose of barbiturates and submerged in bath tub</u>		
20c. TIME OF INJURY Month, Day, Year <u>7 ?</u> <u>xx</u> <u>Sept 27</u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Bethesda</u> <u>Montgomery</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12578

12587

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>1 1/2 hours</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>1053 Buchanan - NE</i>	
3. NAME OF DECEASED (Type or print) <i>Sister Mary Rose Cratow</i>		4. DATE OF DEATH <i>September 21 19 67</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1st - 1936</i>
9. AGE (In years last birthday) <i>31 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RD - Modern Student</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Student</i>	
13. FATHER'S NAME <i>Laurel Cratow</i>		14. MOTHER'S MAIDEN NAME <i>Rose Fortin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>8194</i>	
17. INFORMANT <i>Sister Mary Rose Cratow</i>		Address <i>Suburban Hospital</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Extreme Injuries</i> DUE TO (b) <i>with Internal Hemorrhage</i> DUE TO (c) <i>with Internal Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Deceased, passenger, was thrown from auto which hit guard rail & overturned</i>	
20c. TIME OF INJURY Month, Day, Year <i>6:52 p.m. 9-21 19 67</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>Street</i>	
20e. (City or town) <i>Rockville</i>		(County) <i>Montgomery</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELOEN R. REAP, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>9/23/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Eastern Cemetery</i>		23d. LOCATION (City or town) (County) (State) <i>Montreal, Canada</i>	
24. FUNERAL DIRECTOR <i>Jas. T. Ryan, Inc.</i>		25a. REC'D BY REGISTRAR <i>SEP 25 1967</i>	
ADDRESS <i>317 Pa. Ave., SE DC3</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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CERTIFICATE OF DEATH

12579

12588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN Hospital</u>				d. STREET ADDRESS <u>3108 PARKER AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine Davenport</u> First <u>Virginia</u> Middle <u>Davenport</u> Last				4. DATE OF DEATH Month <u>SEPT</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-14</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.H. INT. RESEARCH</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Hiram E. Heckrott</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Spedden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-10-6188</u>		17. INFORMANT <u>JAMES R. DAVENPORT - Husband -</u> Address <u>3108 Parker Ave. Sil. Spr. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1</u> <u>Bronchopneumonia</u> DUE TO (b) <u>Adenocarcinoma of liver</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/63</u> , 19 <u> </u> , to <u>9/26/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>9/25/67</u> 19 <u> </u> , and that death occurred at <u>3:30</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Henry C. Scruggs MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY C. SCRUGGS MD</u>				22d. ADDRESS <u>5413 Cedarlane Bethesda Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Walter E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Oct 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEMORANDUM FOR THE SECRETARY OF DEFENSE

13

Subject: [Illegible]

Reference: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

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12580

CERTIFICATE OF DEATH

12589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Approved by the ~~Medical Examiner~~ *Medical Examiner*

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>3 Hours</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>2019 Hanover St</i>	
3. NAME OF DECEASED (Type or print) <i>CLIFFORD A. DAVIS</i>		4. DATE OF DEATH <i>9-1-1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-3-08</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Western Electric</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Clay V. Davis</i>		14. MOTHER'S MAIDEN NAME <i>Sidney Rochester</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-07-8618</i>	
17. INFORMANT <i>Mrs. Dorothy C. Davis</i>		Address <i>2019 Hanover Street</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO <i>thrombosis left coronary artery</i> DUE TO <i>coronary artery sclerosis</i> last. <i>2 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>63</i> , to <i>9/1</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>9/1</i> , 19 <i>67</i> , and that death occurred at <i>1:40 M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>H F Kreuzburg</i>		22b. DATE SIGNED <i>9/1/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>H F Kreuzburg</i>		22d. ADDRESS <i>7852-1606 N.W. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept. 5, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Montgomery Md.</i>	
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>		25a. RECEIVED BY REGISTRAR <i>SEP 8 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		26. ADDRESS <i>Warner E. Pumphrey Inc. 8434 Georgia Avenue SS</i>	

CONTINUED ON REVERSE

1887

High Court of Justice
Davis
8-5-08

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12581

CERTIFICATE OF DEATH

12590

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. LENGTH OF STAY IN 1b <u>24 days/Hours</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				15.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>517 Albany Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Nicholas Schellian DeLorse</u>				4. DATE OF DEATH <u>September 26, 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>*Separated</u> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 10, 1889</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Blacksmith</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Theodore DeLorse</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Schillian</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records 7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1533 IMMEDIATE CAUSE (a) <u>Myocardial and pulmonary failure</u> DUE TO (b) <u>Peritonitis following resection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Of sigmoid colon for adenocarcinoma</u> uncertain PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis, severe.</u>							
19. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-1</u> , 19 <u>67</u> , to <u>9-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-25</u> 19 <u>67</u> , and that death occurred at <u>6:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>H. S. Didler</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/26/67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Wellsville New York</u>	
24. FUNERAL HOME <u>W. K. McEwen & Son Funeral Home</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>47-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Nursing Home</u>		d. STREET ADDRESS <u>6313 14th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Dominitz</u>		4. DATE OF DEATH <u>Sept 7 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Hebrew</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1901</u>
9. AGE (In years lost, birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESLADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NATHAN SOROKO</u>		14. MOTHER'S MAIDEN NAME <u>EVA WEIZMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-14-0774</u>	
17. INFORMANT <u>641 Colossee Road, Rockville, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO (b) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>170X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 4</u> , 19 <u>67</u> , to <u>Sept 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 4</u> , 19 <u>67</u> , and that death occurred at <u>6:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Sept 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG</u>		22d. ADDRESS <u>641 Colossee Road, Rockville, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-10-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>NORTON VA.</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C.
SEP 11 1951
MEMORANDUM FOR THE RECORD
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Cleared by Dr. Reed

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12583		CERTIFICATE OF DEATH	
12592			
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS</u>		c. LENGTH OF STAY IN 1b <u>14 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SIMPSONVILLE</u>		d. STREET ADDRESS <u>117 VISTA ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>R.</u> Last <u>DORSEY</u>		4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/36</u>
9. AGE (In years lost birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHYSICIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. OF DEFENSE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN RALPH DORSEY</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE FOX</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs NANCY DORSEY</u>		Address <u>117 VISTA ROAD</u>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO <u>223X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRAIN stem swelling</u> (c) <u>Acoustic neuroma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		49. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/4</u> , 19 <u>67</u> , to <u>9/18</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9/18</u> , 19 <u>67</u> , and that death occurred at <u>3A M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John I. Word</u>		22b. DATE SIGNED <u>9/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John I. Word</u>		22d. ADDRESS <u>1015 Spring St Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>SEPT. 20, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LODON PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MARYLAND</u>	
24. FUNERAL DIRECTOR <u>HARRY WITZKE</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1967</u>	
ADDRESS <u>COLUMBIA PIKE ELYCOTT CITY MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF NEW YORK
IN SENATE
January 1, 1903

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE

1903

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.
1903.

THE LAND OFFICE OF THE STATE OF NEW YORK
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF
THE REPORT OF THE COMMISSIONER OF THE LAND OFFICE
FOR THE YEAR 1902, AND TO TRANSMIT THE SAME
TO THE SENATE AND ASSEMBLY.

IN WITNESS WHEREOF, I HAVE HEREUNTO
SET MY HAND AND SEAL OF OFFICE, AT ALBANY,
THIS 1st DAY OF JANUARY, 1903.

JOHN W. ALLEN,
COMMISSIONER OF THE LAND OFFICE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

10/19/67

12584		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12593	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 35minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS RT 2 Box 114 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) VIRGIL OSWALD DOVE			4. DATE OF DEATH 9 29 19 67		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-7-06		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LANDSCAPE GARDENER		10b. KIND OF BUSINESS OR INDUSTRY Garden-landscaping		11. BIRTHPLACE (County & State, or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BENJAMIN DOVE		14. MOTHER'S MAIDEN NAME SARAH LOWRY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-09-8339		17. INFORMANT Mrs. Virgilio Dove Address Same as	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Severe generalized arteriosclerosis DUE TO (c) 1 hr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 to Sept. 29, 1967 , that (I) (we) last saw the deceased alive on Sept 29 1967 , and that death occurred at 11:55 PM from causes and on the date stated above.					
22a. SIGNATURE Friedrich Moomau		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-29-67	
22c. PHYSICIAN'S NAME (Type) Dr. F. Moomau		22d. ADDRESS Medical center, Sandy Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-2-67		23c. NAME OF CEMETERY OR CREMATORY Parklawn	
23d. LOCATION (City or Town) Rockville		23e. (County) Mont.		23f. (State) Md.	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR OCT 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

Grand A. Barker
Lynchville, Mo.
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Burling

Rockville
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[Faint, mostly illegible handwritten text, possibly a letter or report.]

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12585		12594	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Kansas b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)	c. LENGTH OF STAY IN lb 138 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clay Center	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 717 Court Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Bert E		4. DATE OF DEATH Month Sept. Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1946
9. AGE (In years lost birthday) yrs. 21		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Clay Center, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert E. Downing jr.		14. MOTHER'S MAIDEN NAME Betty Lou Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1965-1967		16. SOCIAL SECURITY NO. 515 50 0503	
17. INFORMANT Mr. Robert E Downing		Address Kansas 717 Court Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 178X IMMEDIATE CAUSE (a) Embryonal carcinoma of testis with widespread metastases DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Apr. 29 , 19 67 , to Sept. 14 , 19 67 that (X) (we) last saw the deceased alive on Sept. 14 , 19 67 , and that death occurred at 1:50 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence A. Jones</i>		22b. DATE SIGNED Sept. 14, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence A. Jones, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-18-1967	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City or Town) (County) (State) Clay Center Kansas
24. FUNERAL DIRECTOR Falls Church Funeral Home		25a. REC'D BY REGISTRAR SEP 21 1967	
Address Home, 1102 West Broad Street, Falls Church, Va		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

CONFIDENTIAL

Gray Center

Gray Center

Gray Center

Gray Center

Gray Center

Gray Center

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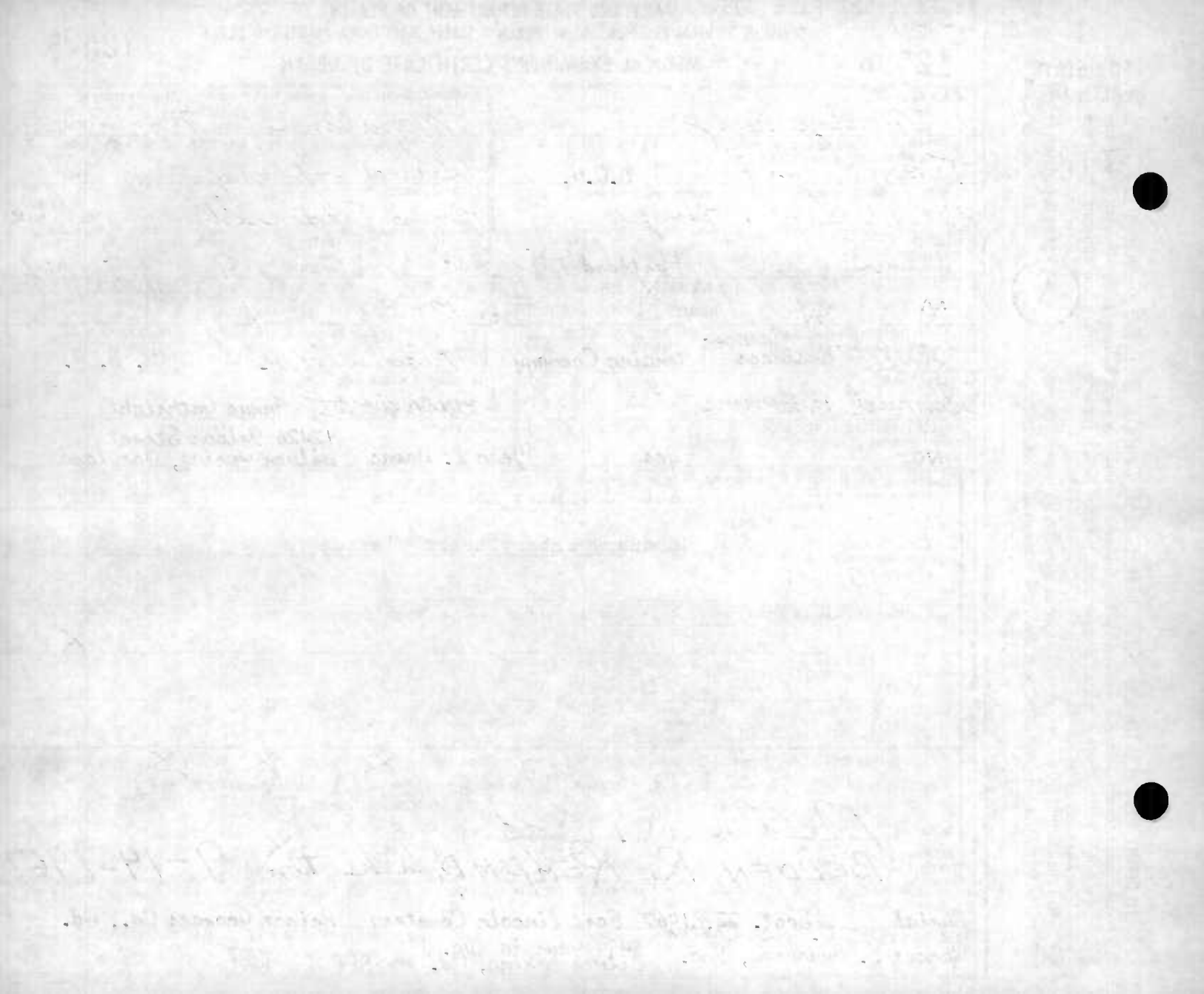
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hosp.</u>		d. STREET ADDRESS <u>12426 Feldon St.</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Hartford Downs</u> Last		4. DATE OF DEATH <u>9</u> Month <u>19</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-30</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Managerial Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vending Company</u>	
11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel H. Downs Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Annys Gathright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Jean L. Downs</u>		Address <u>12426 Feldon Street Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute coronary thrombosis</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>9-19-1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 22, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	
ADDRESS <u>84 14 Georgia Ave. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12587

12596

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
c. LENGTH OF STAY IN 1b 30 days		d. STREET ADDRESS 328 BOYD AVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Villa Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY EMMA DUNGAN		4. DATE OF DEATH 9-7-67	
5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-14-1888 9. AGE (In years lost birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		11. BIRTHPLACE (County & State, or foreign country) New York City	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Hutchinson		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes give war or dates of service)		16. SOCIAL SECURITY NO. 146-01-30738	
17. INFORMANT Mrs. Donald A. Dungan		Address 328 Boyd Ave Takoma Park	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Cerebral thrombosis, congestive heart failure DUE TO (b) Arteriosclerotic cardio-vascular disease DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 15, 1967 , to Sept. 7, 1967 , that (I) (we) last saw the deceased alive on Sept. 5, 1967 , and that death occurred at 4:06 AM , from causes and on the date stated above.			
22a. SIGNATURE Eino Maggi		22b. DATE SIGNED 9-7-67	
22c. PHYSICIAN'S NAME (Type) EINO MAGGI		22d. ADDRESS 831 Univ. Blvd. E., Silver Spring, Md.	
23a. BURIAL/CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 11-1967	
23c. NAME OF CEMETERY OR CREMATORY Admission National		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR Arthur Walters, Takoma Funeral Home		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

STATISTICAL

1937

1. *[Faint, illegible text]*
2. *[Faint, illegible text]*
3. *[Faint, illegible text]*
4. *[Faint, illegible text]*
5. *[Faint, illegible text]*
6. *[Faint, illegible text]*
7. *[Faint, illegible text]*
8. *[Faint, illegible text]*
9. *[Faint, illegible text]*
10. *[Faint, illegible text]*

1

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12583

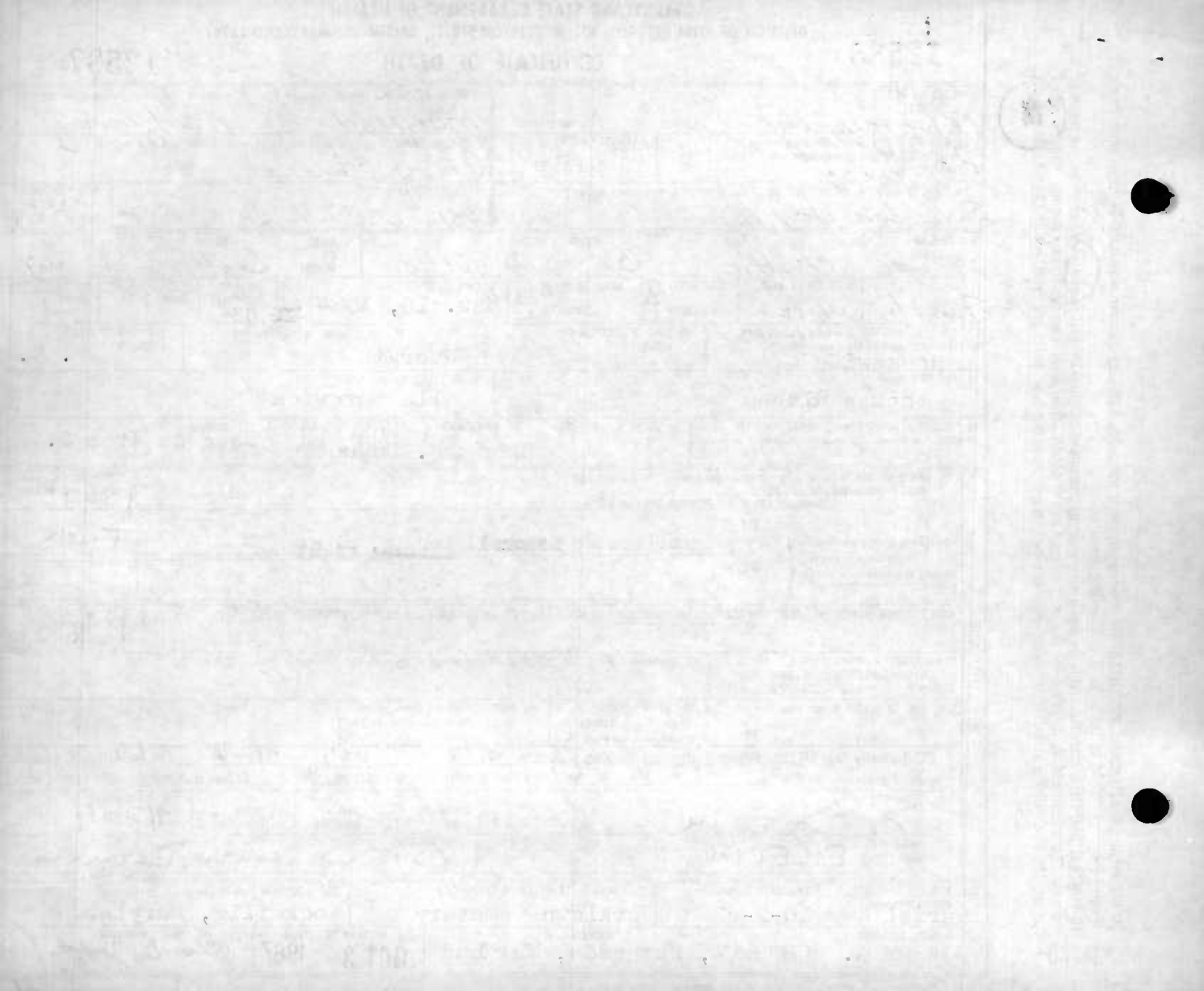
CERTIFICATE OF DEATH

12597

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> 151
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4315 Deland St.</u>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Lottie B. Duquette</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10, 1884</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u>28</u> Days <u>28</u> IF UNDER 24 HRS. Hours <u>28</u> Min. <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Thomas B. Shaw</u>	
14. MOTHER'S MAIDEN NAME <u>Alla Hardwick</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u> <u>Lewis R. Duquette</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO (b) <u>incarcerated femoral hernia, right</u> DUE TO (c) <u>561.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>TWK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> , 19 <u>67</u> to <u>9/28</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>9/27</u> , 19 <u>67</u> and that death occurred <u>9/28</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>E. Levin</u>		22b. DATE SIGNED <u>9/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. LEVIN</u>		22d. ADDRESS <u>8218 Wisconsin Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12589

CERTIFICATE OF DEATH

12598

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner - Liberated

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8701-McLure Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bernard Blakeman Eddy</u> First Middle Last		4. DATE OF DEATH <u>Sept 11</u> 19 <u>67</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 15, 1902</u> 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sherman Eddy</u>		14. MOTHER'S MAIDEN NAME <u>Grace Blakeman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes. U.S. Army</u>		16. SOCIAL SECURITY NO. <u>577-22-1184</u>	
17. INFORMANT <u>Astrid Eddy</u> Address <u>As above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> <u>CARDIAC ARREST</u> DUE TO (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u> <u>30 MIN</u> <u>7 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIA BETES MELLITUS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>66</u> , to <u>SEPT 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>SEPT 3</u> , 19 <u>67</u> , and that death occurred at <u>6:27</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. O'Connor</u> M.D.		22b. DATE SIGNED <u>9/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR</u>		22d. ADDRESS <u>8218 WISCONSIN AVE BETHESDA</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12590			
CERTIFICATE OF DEATH			
12590			
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmoreland Hills c. LENGTH OF STAY IN 1b years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5301 Carvel Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmoreland Hills d. STREET ADDRESS 5301 Carvel Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAUL EDGAR ELICKER First Middle Last		4. DATE OF DEATH Sept. 14, 1967 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1894 9. AGE (In years last birthday) yrs. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ph.D.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Graybill, Penna. 12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME John Elicker		14. MOTHER'S MAIDEN NAME Elizabeth Kuhl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife Elsie Elicker		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Generalized Atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 25 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 1944 , 19 to 9/14 , 19 67 , that (I) (we) last saw the deceased alive on 9/13 , 19 67 , and that death occurred at 11-15 M, from causes and on the date stated above.			
22a. SIGNATURE A. F. Kreglow		22b. DATE SIGNED 9-14-67	
22c. PHYSICIAN'S NAME (Type) A. F. KREGLOW		22d. ADDRESS 4900 Indian Lane Spring, Valley, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-18-67	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Reformed	23d. LOCATION (City or Town) (County) (State) Spring Grove, Penna.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE SEP 20 1967	
ADDRESS Funeral Home Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

STATE OF OHIO

IN SENATE

January 10, 1907

REPORT

OF THE

COMMISSIONER

OF THE

LAND OFFICE

AND

OF

THE

LAND OFFICE

1907

1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12591

CERTIFICATE OF DEATH

12600

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>8105 Hammond Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Thomas</u> Last <u>ELLIOTT</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-88</u>	9. AGE (In years, last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>26</u> Hours <u>15</u> Min. <u>1</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>26</u> Hours <u>15</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Walter Elliott</u>			14. MOTHER'S MAIDEN NAME <u>Bertha Allbright</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-8212</u>		17. INFORMANT <u>A Hospital Record</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Obliterans</u> (c) <u>Arteriosclerosis Obliterans</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>67</u> , to <u>9/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/26</u> 19 <u>67</u> and that death occurred at <u>11:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>K. Cruze</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KENNETH CRUZE</u>				22d. ADDRESS <u>University Blvd E. Silver Spring, Md</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 29 - 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Acacia Memorial Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>River Rd. Pikesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters Washington, DC 20012</u>				25a. REC'D BY REGISTRAR <u>SEP 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

1933

15

Residence of _____

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By _____

Witness _____

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On _____

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12592

CERTIFICATE OF DEATH

12601

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> Maryland b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>31 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. SAN. & Hosp.</u>				d. STREET ADDRESS <u>8317 Eastridge Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Leray Elliott</u>				4. DATE OF DEATH Month Day Year <u>9 12 1967</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 10 - 28 - 1946</u>	9. AGE (In years last birthday) <u>21 yrs.</u>	IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Body Mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Motive</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Leake</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-18-3444</u>		17. INFORMANT <u>Gertude L. Elliott</u> Address <u>402 Clayborn Tr. PH</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus with perforation</u> DUE TO (b) <u>Bilateral pneumonia</u> DUE TO (c) <u>Depn.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 11 - 14, 1967</u> , to <u>SEPT. 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept. 12, 1967</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Albert H. Grollman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN, M.D.</u>				22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville Union</u>		23d. LOCATION (City or Town) (County) (State) <u>Burtonsville Monta. Md.</u>	
24. FUNERAL DIRECTOR <u>J. B. Thomas</u>				25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc 8434 Ga. Ave., S.S. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to page papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12-249727

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ST. MARIS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS Route #2, Box 25-FA	
3. NAME OF DECEASED (Type or print) John Paul ELLIS		4. DATE OF DEATH Month September Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard R. Ellis		14. MOTHER'S MAIDEN NAME Amy Louise Bergmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Howard R. Ellis, Route #2, Box 25-FA		Address Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7545 IMMEDIATE CAUSE (a) Congenital heart defect DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Sept. 10 , 19 67 , to Sept. 11 , 19 67 , that (X) (we) last saw the deceased alive on Sept. 11 , 19 67 , and that death occurred at 6:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Frank J. Tomasevic, M.D.		22b. DATE SIGNED Sept. 12, 1967	
22c. PHYSICIAN'S NAME (Type) Frank J. Tomasevic, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-13-67	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Methodist Seminary		23d. LOCATION (City or Town) (County) (State) Leonardtwn Md.	
24. FUNERAL DIRECTOR Mattingly Funeral Home		25a. REC'D BY REGISTRAR SEP 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

12594

12603

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u>	
c. LENGTH OF STAY IN lb <u>23 days</u>		d. STREET ADDRESS <u>326 Grove Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Raymond Eskildsen</u>		4. DATE OF DEATH Month Day Year <u>September 25 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 October 1913</u>
9. AGE (In years last birthday) <u>53 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Kristen Eskildsen</u>		14. MOTHER'S MAIDEN NAME <u>Hansine Lund</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1941-1945</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral hemorrhagic bronchopneumonia</u> DUE TO (b) <u>Gram negative septicemia</u> DUE TO (c) <u>Acute myelogenous leukemia</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>A[Acute renal failure. B[Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 week</u> <u>1 month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>25</u>
21. I certify that <u>I</u> (this hospital) attended the deceased from <u>September 2 19 67</u> , to <u>September 2 19 67</u> that <u>I</u> (we) last saw the deceased alive on <u>September 25 19 67</u> , and that death occurred at <u>2:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>David L. Lilien</u>		22b. DATE SIGNED <u>25 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>David L. Lilien, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 27, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>
24. FUNERAL DIRECTOR <u>Covington-Martin Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 29 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

James L. Smith

CERTIFICATE OF DEATH

12604

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (rural)		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 12508 BRADDOCK RD.	
3. NAME OF DECEASED (Type or print) VADA P FERGUSON		4. DATE OF DEATH Month SEPT. Day 19 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897 17 APRIL 1887
9. AGE (In years lost birthday) 7X70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WILKES BARRE, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEE PARSONS		14. MOTHER'S MAIDEN NAME JULIA CHURCH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT CHARLOTTE BLEVINS		Address 12508 BRADDOCK RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus, massive DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombophlebitis, legs, deep DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 15 SEPT., 1967 , to 19 SEPT., 1967 , that (I) (we) last saw the deceased alive on 19 SEPT. 1967 , and that death occurred at 3 P M, from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence W. Raymond</i>		22b. DATE SIGNED 20 Sept. 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence W. Raymond, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY THOMAS BRIDGE CEMETERY	23d. LOCATION (City or Town) (County) (State) MARION VA.
24. FUNERAL DIRECTOR BARNETT'S FUNERAL HOME		25a. REC'D BY REGISTRAR SEP 27 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		26. RECORDING OFFICE	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12596

12605

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>22 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>212 St. Lawrence Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Henry</u> Last <u>Fillius</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-04</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Milton J. Fillius</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Speiser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-8127</u>	
17. INFORMANT <u>Maud G. Fillius</u>		18. ADDRESS <u>212 St. Lawrence Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO (b) <u>Adenocarcinoma of Colon with</u> DUE TO (c) <u>massive liver metastases.</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>9/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/18</u> , 19 <u>67</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold</u>		22b. DATE SIGNED <u>9/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold</u>		22d. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George Co. Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15 (4)
25M 1/67

Cleared with Medical Examiner - Dr. B. Reaf. 9/25/67

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12597

CERTIFICATE OF DEATH

12606

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 47 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Villa Nursing Home		d. STREET ADDRESS 807 Butternut Street, N.W.	
3. NAME OF DECEASED (Type or print) Ellen Edith Firor		4. DATE OF DEATH Month Sept. Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1880
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Belvedere, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Bittenbender		14. MOTHER'S MAIDEN NAME Agnes Bittenbender LITZENBERGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 320-03-2028-B	
17. INFORMANT Patient's Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction DUE TO Congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/3/67 , 19 67 , to 9/12/67 , 19 67 , that (I) (we) last saw the deceased alive on 9/11/67 , 19 67 , and that death occurred at 11 A.M. from causes and on the date stated above.			
22a. SIGNATURE Charles H. Walters		22b. DATE SIGNED 9/12/1967	
22c. PHYSICIAN'S NAME (Type) Charles H. Walters		22d. ADDRESS 831 University Blvd E. Sd. J. Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE THEREOF Sept 15, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Mausoleum	23d. LOCATION (City or town) (County) (State) Suitland, Pk Co. Md
24. FUNERAL DIRECTOR Charles Walters, 254 Carroll St NW DC		25a. REC'D BY REGISTRAR SEP 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

15503

UNITED STATES

Washington, D.C.

Department

Division

Colonial Office

For Secretary

Page 11

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Washington, D.C.

Colonial Office

For Secretary

Colonial Office

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FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12607

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. 11100 Ralston Rd.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN 1b Rockville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Marylander		d. STREET ADDRESS 11100 Ralston Road	
3. NAME OF DECEASED (Type or print) KATIE		4. DATE OF DEATH Month Sept. Day 1 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1881
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Conway, S.C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James O'Gilrie		14. MOTHER'S MAIDEN NAME Emma O'Gilrie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-54-7321	
17. INFORMANT Mrs. R.H. Mitchell		Address 11100 Ralston Rd. Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Insufficiency Acute DUE TO (b) Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		22. DATE SIGNED 9-1-67	
EXAMINER'S NAME (Type) JOHN G. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/1/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem.		23d. LOCATION (City or Town) (County) (State) New Bern, North Carolina	
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR SEP 8 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

1900

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12599

12608

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN TB <u>years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7208 Brennon Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara</u> First Middle Last		4. DATE OF DEATH <u>Sept. 27</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/96</u> 70 yrs.
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MICHIGAN</u>	
11. BIRTHPLACE (State or foreign country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ERIC LUNDSELL</u>		14. MOTHER'S MAIDEN NAME <u>WILHEMINA JOHNSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SCOTT E. FORBUSH 7208 BRENNON</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma, left breast</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Ball</u> M.D.		22. DATE SIGNED <u>9/28/67</u>	
EXAMINER'S NAME (Type) <u>John E. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, or other disposal <u>Cremation</u>	23b. DATE THEREOF <u>9-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lees Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300 4th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13800

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

OCT 1 1951

12600

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>64 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>9604-Bulbs Run Parkway</u>	
3. NAME OF DECEASED (Type or print) <u>James H. Fox</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/14/23</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dr. J. I. H.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Phila. Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>R. Maurice Fox</u>	
14. MOTHER'S MAIDEN NAME <u>Georgia VanScindlen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>189-16-3156</u>		17. INFORMANT <u>Wife Rita Fox (Same as above)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (b) <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>63</u> , to <u>Sept 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 17</u> , 19 <u>67</u> , and that death occurred at <u>9:25</u> P.M., from causes on the date stated above.			
22a. SIGNATURE <u>Robert N. Coale</u>		22b. DATE SIGNED <u>Sept 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		22d. ADDRESS <u>4429 Bradley Lane, Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>9-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	
ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1588

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12601

12610

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Forsyth</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keenersville</u>		70-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Linville Ct. B #3</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gustav E. Friedenber</u>		4. DATE OF DEATH <u>Sept 23 1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 17 1898</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RETIRED CLERGYMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGION</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward FRIEDENBERG</u>		14. MOTHER'S MAIDEN NAME <u>Julia Kuyuth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>Son - Walter Friedenber</u>		Address <u>5608 Loma Ct. Beth. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Generalized Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Previous Cerebrovascular occlusion</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 18</u> , 1967, to <u>Sept 23</u> , 1967, that (I) (we) last saw the deceased alive on <u>Sept 21</u> , 1967, and that death occurred at <u>10:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Stanley M. Bialek</u>		22b. DATE SIGNED <u>9/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>STANLEY M. BIALEK</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Beth. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>9/25/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, MD.</u>	
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1881

CERTIFICATE OF DEATH

1881

[Faint, illegible handwriting, likely bleed-through from the reverse side of the page.]

[Faint, illegible handwriting, likely bleed-through from the reverse side of the page.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

12602

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12611

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.			c. LENGTH OF STAY IN Ib DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 3027 Kramer St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Rebecca		Last Furcolow		4. DATE OF DEATH Month 18 , Sept, 67 Day 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 11, Feb, 25	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 42		IF UNDER 24 HRS. Days 42		Hours 42 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mississippi	
12. CITIZEN OF WHAT COUNTRY U. S. A.				13. FATHER'S NAME LeRoy Mc Ewen			
14. MOTHER'S MAIDEN NAME Edris Gilmore				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 432-34-0493				17. INFORMANT William H. Furcolow			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Acute Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap				22. DATE SIGNED 9/19/1967			
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Wheaton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 20, 1967		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR B. Thomas				25a. REC'D BY REGISTRAR SEP 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
26. FUNERAL HOME Warner E. Pumphrey, Inc.				27. ADDRESS 8434 Georgia Ave. Silver Spring, Md.			

Montgomery

Montgomery

Montgomery

Montgomery

100

Silver Spring, Md.

1907

Holy Cross Hospital

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11, 200, 00

Female White

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12603

Item #9 Film #G393 10/11/67 ph

12612

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sil. Sprg. Md. c. LENGTH OF STAY IN 1b 1 hr		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospt.		d. STREET ADDRESS 10721 Meadowhill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Vernell H Giebel		4. DATE OF DEATH Month Day Year 9 27 67	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/98 9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ? Reynolds	
14. MOTHER'S MAIDEN NAME May Estes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Holy Cross 1500 Forest Glen Rd. SSMd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage, rupture of DUE TO (b) intracranial aneurysm DUE TO (c) unknown 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr , 1967, to 27 Sept , 1967, that (I) (we) last saw the deceased alive on 7 Sept 1967, and that death occurred at 11 A M , from causes and on the date stated above.			
22a. SIGNATURE Robert T. Kelley M.D.		22b. DATE SIGNED 27 Sept 67	
22c. PHYSICIAN'S NAME (Type) ROBERT T. KELLEY M.D.		22d. ADDRESS 1302-18TH ST. N.W. WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-30-67	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	23d. LOCATION (City or Town) (County) (State) SILVER SPRING MD.
24. FUNERAL DIRECTOR Thomas B. Hannon		25a. REC'D BY REGISTRAR DATE OCT 5/ 1967	
		25b. REGISTRAR'S SIGNATURE John J. Judge	

ISSUE

RECEIVED

1901



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12604

CERTIFICATE OF DEATH

12613

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN lb <u>10 1/2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>200 Martins Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>R</u> Last <u>Gilmore</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>8</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-95</u> 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Gilmore</u>		14. MOTHER'S MAIDEN NAME <u>Carrie ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of prostate</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> , 19 <u>67</u> , to <u>9/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/7/68</u> 19 <u>67</u> , and that death occurred at <u>1A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Ronald W. Barr</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>RONALD W. BARR</u>		22d. ADDRESS <u>10461 OLD GEORGETOWN RD BETHESDA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Sept. 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1884

CENTRAL OF OREGON

1884

Chrysomelidae
Chrysomelidae

7/1/88
Rogers & Co.
Portland

7/1/88

John C. Rogers & Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12605						12614					
Item #2a, b, c & d Film #352 9/18/67											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>MD/D.C.</u> b. COUNTY <u>MONTGOMERY CO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>				d. STREET ADDRESS <u>3615 8101 - 16th St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>						e. IS RESIDENCE ON A FARM? <u>NO</u>				f. IS RESIDENCE ON A FARM? <u>NO</u>	
3. NAME OF DECEASED (Type or print) First <u>ISAAC "IKE"</u> Middle <u>GOLDBLATT</u> Last <u>GOLDBLATT</u>						4. DATE OF DEATH Month <u>SEPT</u> Day <u>12</u> Year <u>19 67</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/4/78</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOVIE PICTURE OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PICTURES</u>		11. BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAX JACOB GOLDBLATT</u>						14. MOTHER'S MAIDEN NAME <u>LINTHOM</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>053-34-9084</u>		17. INFORMANT <u>MAX J. GOLDBLATT-Son</u>		Address <u>6101-26th St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Sclerotic</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Enter traumatic Sp. (C) hips</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Yes (C) hips</u>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Yes (C) hips</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>8/12/67</u> e.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Wash. D.C.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>8/20/67</u> to <u>9/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/11</u> 19 <u>67</u> and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Boyd J. Schenker</u>						22b. DATE SIGNED <u>9/12/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Boyd J. Schenker</u>						22d. ADDRESS <u> </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>9/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNION FIELDS CEM. GREENS</u>				23d. LOCATION (City, town or county) (State) <u>MD</u>	
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERIAL HOME</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>SEP 14 1967</u>											

23031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

12606				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12615			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
a. COUNTY MONTGOMERY		MARYLAND		a. STATE Maryland		b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN lb 1 yr 9 1/2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS SANITARIUM				d. STREET ADDRESS 5303-38 Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH							
First Middle Last DORA L. GOVER				Month Day Year SEPT 1 1967							
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 21 1887		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas Leitch				14. MOTHER'S MAIDEN NAME ANNIE DORSEY							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-83990X		17. INFORMANT Elizabeth Heagy University Park Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arterio sclerosis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 10 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from Nov 19, 1967 to 9/1, 1967 that (I) (we) last saw the deceased alive on 8/31, 1967 , and that death occurred at 8:30 M. from causes and on the date stated above.											
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/1/67					
22c. PHYSICIAN'S NAME (Type) H. E. Kreuzburg				22d. ADDRESS 7852 16th Ave Wash DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		23d. LOCATION (City or Town) (County) (State) Friendship Md					
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 5 1967					
				25b. REGISTRAR'S SIGNATURE [Signature]							

13012

INSTRUMENT OF DEED

13012

[Faint, mostly illegible text, likely a deed or legal instrument, spanning the main body of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12607

CERTIFICATE OF DEATH

12616

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 517 Buchanan St., NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Thomas Green First Middle Last		4. DATE OF DEATH 9 5 1967 Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1900 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ada Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wm. Green-517 Buchanan St., NW, DC Address Wash.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH one month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Urinary Infection		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/21 , 19 67 to 9/5 , 19 67 that (I) (we) last saw the deceased alive on 9/2 , 19 67 , and that death occurred at 8:45 M, from causes and on the date stated above.			
22a. SIGNATURE Russell & Bufalino M.D.		22b. DATE SIGNED Sept 5, 1967	
22c. PHYSICIAN'S NAME (Type) Russell, Bufalino, M.D.		22d. ADDRESS 1429 University Blvd., West, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/7/67	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Landover Md.
24. FUNERAL DIRECTOR Johnson & Jenkins		25a. REC'D BY REGISTRAR 4804 Ga Ave N.W.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 11 1967	

13818

UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

12608		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12617	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Hospital & Sanitarium				d. STREET ADDRESS 1414 Nicholson Street N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas A. (XXXX) Griffin				4. DATE OF DEATH Month Day Year September 1 1967	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 25, 1877 XXXXXX		9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Department employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) District of Columbia	
13. FATHER'S NAME Thomas Griffin				14. MOTHER'S MAIDEN NAME Mary Mulkerin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-36-2863A		17. INFORMANT William R. Griffin Jr. Address Silver Spring Md. Medical chart 11405 Nairn Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5020 old age DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) massive bronchitis + emphysema DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1952, 19, to Sept 1, 1967, that (I) (we) lost saw the deceased alive on Sept 1, 1967, and that death occurred at 2:15 P.M. from causes and on the date stated above.					
22a. SIGNATURE Philip Bloemsma		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept 1, 1967	
22c. PHYSICIAN'S NAME (Type) Philip Bloemsma		22d. ADDRESS 7701 Conn. Ave. Chevy Chase, Md.			
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE THEREOF 9/4/67		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery Washington, D.C.	
23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR Joseph Gawler		25a. REC'D BY REGISTRAR SEP 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1987

7. The following information is provided for the year ended 31 March 2014:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12609					12618				
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> <u>1571</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9900 Old Spring Road</u>					d. STREET ADDRESS <u>9900 Old Spring Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carolyn Giles Groff</u>			First Middle Last		4. DATE OF DEATH <u>September 26 1967</u>		Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 2, 1901</u>		9. AGE (In years last birthday) <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James L. Giles</u>					14. MOTHER'S MAIDEN NAME <u>Nettie B. Nicholson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>578-58-4480</u>		17. INFORMANT <u>Husband</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Dissecting Aortic Aneurysm</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>20 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 13, 1966</u> , to <u>Sept 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 25 1967</u> , and that death occurred at <u>7⁰⁰ AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert B. Havell</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 26, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert B. Havell MD</u>						22d. ADDRESS <u>5516 Nebraska Ave - DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

18818

CERTIFICATE OF DEATH

18818

THE STATE OF NEW YORK, COUNTY OF ALBANY,

BEFORE ME, the undersigned authority, on this day personally appeared

JOHN J. HARRIS, known to me to be the person whose name is subscribed to the foregoing certificate,

and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office at Albany, New York, this day of

1900.

Notary Public in and for the State of New York.

JOHN J. HARRIS

JOHN J. HARRIS

JOHN J. HARRIS

JOHN J. HARRIS

JOHN J. HARRIS

JOHN J. HARRIS

JOHN J. HARRIS

JOHN J. HARRIS

JOHN J. HARRIS

JOHN J. HARRIS

JOHN J. HARRIS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12610

12619

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shiloh Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Washington 11201 Georgia Ave</u>		d. STREET ADDRESS <u>1115 Wisconsin Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Rose T. Grundstein</u>		4. DATE OF DEATH <u>Sept 9 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ben Halenky</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Pieloff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-54-5090</u>	
17. INFORMANT <u>Mrs. Anne Grundstein</u>		Address <u>4000 15th Ave. Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Chronic Myocardial Disease</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>7-9-67</u>	
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-11-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CHESEDENES CEM.</u>		23d. LOCATION (City or town) (County) (State) <u>CLEVELAND OHIO</u>	
24. FUNERAL DIRECTOR <u>Goodbye Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
ADDRESS <u>4217 9th St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12611

CERTIFICATE OF DEATH

12620

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>5610 Southwick St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>L.</u> Last <u>Haight</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>3</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/25/90</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>	
13. FATHER'S NAME <u>Henry S. Haight</u>			14. MOTHER'S MAIDEN NAME <u>Phoebe Sneed</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07-9735A</u>		17. INFORMANT <u>Doris O. Haight</u> Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Coronary arteriosclerosis with thrombosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchopneumonia, pyelonephritis, acute and chronic, Carcinoma U. Blad.</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-29</u> , 19 <u>67</u> , to <u>9-3-</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9-3-</u> 19 <u>67</u> , and that death occurred at <u>2:10 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Ronald W. Barr</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9-4-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>RONALD W. BARR</u>		22d. ADDRESS <u>10410 Old Georgetown Rd. Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13230

UNIVERSITY OF MICHIGAN

1921

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12612

CERTIFICATE OF DEATH

12621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Wash. D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 9 Mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wash. D.C.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Althea Woodland Nursing Home		d. STREET ADDRESS 2500 Q St. N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Sara S. Hamner		4. DATE OF DEATH Month Day Year SEPT 19 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-1886
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Mississippi
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Thomas A. Sale	
14. MOTHER'S MAIDEN NAME Ann Thrower		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Longstreet 2500 Q St. N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Cerebral thrombosis DUE TO Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH stat.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 1966 to 9-19-1967 that (1) (we) last saw the deceased alive on 9-9-1967 and that death occurred at 8:55 AM from causes and on the date stated above.			
22a. SIGNATURE Robert S. Poole		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9-19-67
22c. PHYSICIAN'S NAME (Type) ROBERT S. POOLE		22d. ADDRESS 4501 CONN AVE.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-22-1967	23c. NAME OF CEMETERY OR CREMATORY Old Odd Fellows	23d. LOCATION (City or Town) (County) (State) Aberdeen Miss.
24. FUNERAL DIRECTOR Jos. Gawler		25. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE Jos. Gawler		25c. ADDRESS 8s Sons 5130 Wisc. Ave. N.W.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12622

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Spring Nursing Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>J. Patricia Hannan</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 17, 1902</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>57</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DANIEL SULLIVAN</u>				14. MOTHER'S MAIDEN NAME <u>AGNES SHEEHY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>NURSING HOME RECORDS.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>X Heart</u> DUE TO <u>Cerebral Vascular Decedent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Cerebral Arterio Sclerosis</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/16/67</u> , 19 <u>67</u> to <u>9/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/16/67</u> , and that death occurred at <u>8 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>William P. Gray Sr.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/16/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>William P. Gray Sr. M.D.</u>		22d. ADDRESS <u>7005 Maple A Chevy Chase Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>			
24. FUNERAL DIRECTOR <u>HANLON FUNERAL HOME-</u>				ADDRESS <u>WASH. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 25 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12614

CERTIFICATE OF DEATH

12623

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>P.O.A.</u>		16	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>1636 University Blvd. E.</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID</u> First <u>Rambo</u> Middle <u>XXXXXXXXXX</u> Last <u>HARKER</u>		4. DATE OF DEATH <u>Sept. 20</u> 19 <u>67</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		9. AGE (In years last birthday) <u>60</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store Woodward & Lothrop</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Trenton, New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>David R. Harker</u>	
14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXX Georgianna Cooper</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>(no)</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>720-14-6370</u>		17. INFORMANT <u>Mrs. Jean L. Pannoni</u> Address <u>Step. daughter 1636 Univ. Blvd. E.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4200</u> IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 mos</u> <u>24 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>adenocarcinoma right kidney - 65 mos.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this husband) attended the deceased from <u>4/23</u> , 19 <u>62</u> , to <u>9/20</u> , 19 <u>67</u> , that (I) (the) lost saw the deceased alive on <u>9/17</u> , 19 <u>67</u> , and that death occurred at <u>6:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Harry N. Carlton</u>		22b. DATE SIGNED <u>9/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>		22d. ADDRESS <u>8811 Colesville Rd., S.S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> ADDRESS <u>8434 Georgia Ave.</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Md.</u>	

15003

RECORDS OF DEATH

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James George

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John

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Item #7 Film #G392 9/27/67 ph

CERTIFICATE OF DEATH

12624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6820 - The Georgetown Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Thorothy J. Halperman</u>		4. DATE OF DEATH <u>Sept. 14 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/13/94</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>S. Wales</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Robert Halperman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Newton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Patricia Nelson</u>		Address <u>Bethesda</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction, multiple, bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>atrial thrombosis</u> DUE TO (c) <u>arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April, 1966</u> to <u>Sept 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 14, 1967</u> , and that death occurred at <u>3:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/15/67</u>
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER, M.D.</u>		22d. ADDRESS <u>8218 Wisc. Av. Beth, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/18/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	23d. LOCATION (City or Town) (County) (State) <u>SILVER SPRING - MONT. - MD.</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers</u>		ADDRESS <u>Silver Spring Md</u>	25a. REC'D BY REGISTRAR <u>SEP 19 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

5268

CERTIFICATE OF DEATH

12625

12616

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 3016/Buchanan Street	
3. NAME OF DECEASED (Type or print) First Brian Middle C. Last HART		4. DATE OF DEATH Month September Day 28 Year 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1967
9. AGE (In years last birthday) — yrs.		IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Quantico, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick T. Hart		14. MOTHER'S MAIDEN NAME Frances Rams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Buchanan St. Address Arlington, Va. LCDR Patrick T. Hart, USN, 3016 South			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Distress DUE TO 771.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Hemorrhage DUE TO (c) Bilateral Subdural Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Sept. 27, 1967 , to Sept. 28, 1967 , that he (we) last saw the deceased alive on Sept. 28, 1967 , and that death occurred at 1230 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 1967 28 September	
22c. PHYSICIAN'S NAME (Type) T. X. LOEB, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR <i>[Signature]</i> Falls Church Funeral Home 1102 West Broad St., Falls Church, Va.		25. RECEIVED BY REGISTRAR OCT 3 1967 DATE	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

2235

Nonlinear

VOLUME 15 NUMBER 1

2003年12月 第12卷第12期

• K. ICHIKAWA •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

68

2

1

VR A15 (4)
25M 1/67

12617

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12626

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>SOUTH CAROLINA</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COTTAGEVILLE</u>		773	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>P.O. Box 13</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RUFUS</u> Middle <u>D.L.</u> Last <u>HARVEY</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 12, 1901</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill Machinery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>249-03-7448</u>	
17. INFORMANT <u>MRS. ARLENE REGISTER</u>		Address <u>2923 UNIVERSITY BLVD KENSINGTON, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with Rt. Hemiplegia</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 Days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>auricular Fibillation and Rt. Bundle Branch Block</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>AUG. 1</u> , 19 <u>67</u> , to <u>SEPT. 18</u> , 19 <u>67</u> , that (1) (we) lost saw the deceased alive on <u>SEPT. 18</u> , 19 <u>67</u> , and that death occurred at <u>3:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>James A. Roberts</u>		22b. DATE SIGNED <u>SEPT. 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u>		22d. ADDRESS <u>8907 GEORGIA AVE. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-Burial</u>		23b. DATE THEREOF <u>Sept. 21, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>North Charleston, S. C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

85558

CHARTER OF DRAFT

1013

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "CHARTER" and "DRAFT" are visible.]



4
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12618

CERTIFICATE OF DEATH

12627

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> <u>10403 Brunswick Ave</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 wks.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>10403 Brunswick Ave</u> <u>Forest Glen, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Martha Leta Hasselbring</u>		4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1900</u>
9. AGE (In years lost birthday) <u>66</u> YRS.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Monticello, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles D. Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Lida M. Straight</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>312-22-2554</u>	
17. INFORMANT <u>Fred C. Hasselbring</u>		Address <u>10403 Brunswick Ave.</u> <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> DUE TO (b) <u>Pneumatoid Arthritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ASHD</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/15/65</u> to <u>9/5/67</u> , that (I) (we) last saw the deceased alive on <u>9/5/67</u> , and that death occurred at <u>2:25 PM</u> from causes and on the date stated above			
22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>9/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry, M.D.</u>		22d. ADDRESS <u>10620 Georgia Ave., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-Burial Sept. 10, 1967</u>	23b. DATE THEREOF <u>Sept. 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u> <u>Monticello, Indiana</u>	23d. LOCATION (City or Town) (County) (State) <u>Monticello, Indiana</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			

1941

CERTIFICATE OF DEATH

1941

John J. Gentry, Jr.
Born: 2/11/1917
Died: 1/15/1941
Cause of Death: ...
Place of Death: ...
Buried: ...
Witness: ...
Registrar: ...

John J. Gentry, Jr.
Born: 2/11/1917
Died: 1/15/1941
Cause of Death: ...
Place of Death: ...
Buried: ...
Witness: ...
Registrar: ...

12613

CERTIFICATE OF DEATH

12628

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Onney		c. LENGTH OF STAY IN lb 1 hr. 42 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS 4324 Kenbury Dr.	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Hawkins		4. DATE OF DEATH Month Day Year 9/17/67	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/67
9. AGE (In years lost birthday) yrs. 8		IF UNDER 1 YEAR Months Days Hours Mins. 1 42	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy B. Hawkins		14. MOTHER'S MAIDEN NAME Linda L. Whetzel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Leroy B. Hawkins, Item 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 776X Prematurity IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 26 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-17, 1967 , to 9-17, 1967 , that (I) (we) last saw the deceased alive on 9-17, 1967 , and that death occurred at 4:45 AM , from causes on and on the date stated above.			
22a. SIGNATURE L.S. Batman		22b. DATE SIGNED 9/17/67	
22c. PHYSICIAN'S NAME (Type) L. S. Batman, M.D.		22d. ADDRESS Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 19, 1967	23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.	23d. LOCATION (City or Town) (County) (State) Damascus, Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1955

RECORD OF DEATH

1955

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Married

Married

May

Married

Married

Married

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12620

12629

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RANDOLPH HILLS NURSING HOME</u>		d. STREET ADDRESS <u>4107 PLYERS MILL Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>BENJAMIN C. HAWKINS</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-1880</u>
9a. AGE (In years last birthday) <u>87</u> yrs.		9b. IF UNDER 1 YEAR Months <u>87</u> Days <u>87</u> Hours <u>87</u> Min. <u>87</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JAMES HAWKINS</u>		14. MOTHER'S MAIDEN NAME <u>LIZA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219-12-47664</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>Carcinoma liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma liver</u> DUE TO <u>Carcinoma liver</u> (c) <u>Carcinoma liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/1/67</u> , 19 <u>67</u> , to <u>9/16/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/15</u> , 19 <u>67</u> , and that death occurred at <u>1 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Patricia C. Jamerson</u> M.D.		22b. DATE SIGNED <u>9/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Patricia C. Jamerson</u>		22d. ADDRESS <u>11718 Georgia Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Sandy Spring Md, Md</u>	
24. FUNERAL DIRECTOR <u>George R. Snowden</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

Publ. 1888
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12621		12630	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 5502 40th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kyle G Hawthorne		4. DATE OF DEATH Month September Day 18 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/04
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min. 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Town & Casual Shoes	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noah B Hawthorne		14. MOTHER'S MAIDEN NAME Nettie Grant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215 07 2098	
17. INFORMANT Marguerite Hawthorne		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA, GRAM NEGATIVE DUE TO (b) PERITONITIS, GENERALIZED DUE TO (c) PERFORATED SMALL INTESTINE			INTERVAL BETWEEN ONSET AND DEATH 12 DAYS 12 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, A.S.H.D., OBESITY			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-7 , 19 67 , to 9-18 , 19 67 , that (I) (we) lost the deceased alive on 9-18 , 19 67 , and that death occurred at 8:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Leonard L. Deitz		22b. DATE SIGNED 9/19/67	
22c. PHYSICIAN'S NAME (Type) Leonard Deitz, M.D.		22d. ADDRESS 1111 Spring Street, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE SEP 21 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

DEPARTMENT OF HEALTH

LABORATORY

Office of Health

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Holy Cross Hospital

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STATIONER, 1010 14th Street

PERMANENTLY ESTABLISHED

PERMANENT SMALL BUSINESS

Don't let your business

Don't let your business

Leonard Delle, M.D.

1111 14th Street, Silver Spring, Md.

Don't let your business

Don't let your business

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12622						12631					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Capoma Park</u> c. LENGTH OF STAY IN 1b <u>5 1/2 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6720 Conway Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JOHN WILLIAM HAYES</u>			4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1967</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>July 8, 1909</u>			9. AGE (In years last birthday) <u>72</u> yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Maritime Exam</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Connecticut</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Hayes</u>			14. MOTHER'S MAIDEN NAME <u>Not Available</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>715-03-5719</u>		
17. INFORMANT <u>Hospital Records</u>			Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Coronary Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec, 1958</u> , to <u>9-21, 1967</u> , that (I) (we) last saw the deceased alive on <u>9-20 1967</u> , and that death occurred at <u>12:58 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Gilbert B. Cusher</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>9-21-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>GILBERT B. CUSHER</u>						22d. ADDRESS <u>11161 New Hamp. Ave Silver Spring Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>Sept 23-1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Rest of Annapolis Shores Md</u>			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <u>Arthur Waters</u>			ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20012</u>			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
DATE <u>SEP 22 1967</u>											

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JANUARY 10 1885
JANUARY 10 1885

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "received" and "January" are faintly visible.]

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12632

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg,	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg	
c. LENGTH OF STAY IN b 83 yrs		d. STREET ADDRESS 14 Park Ave	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 14 Park Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle Elizabeth Last Heim		4. DATE OF DEATH Month Sept Day 28th Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6th 1884
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 8 Days 15	11. IF UNDER 24 HRS. Hours 15 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home work		10b. KIND OF BUSINESS OR INDUSTRY III	
11. BIRTHPLACE (County & State, or foreign country) Gaithersburg, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Edward Heim		14. MOTHER'S MAIDEN NAME Malinda Kemp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 14 Park Ave	
17. INFORMANT Leila G. Briggs. Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) Broncho-pneumonia (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 hrs 3 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-25-1967 to 9-28-1967 , that (I) (we) last saw the deceased alive on 9-28-1967 , and that death occurred at 11 PM , from the causes and on the date stated above.			
22a. SIGNATURE F.J. Broschant M.D.		22b. DATE SIGNED 9-29-67	
22c. PHYSICIAN'S NAME (Type) F.J. Broschant		22d. ADDRESS 11 Hutton St Gaithersburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10 Oct 1st 67	23c. NAME OF CEMETERY OR CREMATORY Forest Oak	23d. LOCATION (City, town or county) (State) Gaithersburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Garther. Gaithersburg, Md.		25a. REC'D BY REGISTRAR OCT 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

12633

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 15-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 9039 Sligo Creek Pkwy		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert A. Heller		4. DATE OF DEATH Month September Day 1 Year 1967		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. BIRTH DATE 11-18-12		9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager, Shoe Dept.		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY HELLER		14. MOTHER'S MAIDEN NAME SADIE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rosalind Heller Creek Pkwy. S.S.M.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 ASHD E acute myocardial infarction - recurrent		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 1) Diabetes mellitus & Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-21 , 19 66 , to 9-1 , 19 67 , that (I) (we) last saw the deceased alive on 9-1 , 19 67 , and that death occurred at 7:31 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert S. Waldman M.D.		22b. DATE SIGNED 9-1-67	
22c. PHYSICIAN'S NAME (Type) Robert S. Waldman, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/3/67	
23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gar.		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons St. NW., Wash. DC		25a. REC'D BY REGISTRAR SEP 5 1967	
25b. REGISTRAR'S SIGNATURE Francis Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12625		12634	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Na/N.C. b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Na Midway Park	
c. LENGTH OF STAY IN Ib 2 Days		d. STREET ADDRESS Na 315 Butler Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital Bethesda, Maryland		e. IS RESIDENCE ON AN ARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Lee HELTON Jr.		4. DATE OF DEATH Month 9 Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Na DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 AUG 1967
9. AGE (In years last birthday) yrs. 00 20		10. IF UNDER 1 YEAR Months 00 Days 20 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Na		10b. KIND OF BUSINESS OR INDUSTRY Na	
11. BIRTHPLACE (County & State, or foreign country) Camp Lejeune, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Lee Helton Sr.		14. MOTHER'S MAIDEN NAME Phyllis Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Na Na		16. SOCIAL SECURITY NO. Na	
17. INFORMANT David Lee Helton Sr. Midway Park, N.C.		18. 315 Butler Drive	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7540 Congenital Heart Disease DUE TO (b) Tetralogy Of Fallot DUE TO (c) None			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Na		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Na	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Na 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Na	20f. (City or town) (County) (State) Na
21. I certify that (I) (this hospital) attended the deceased from 2 Sept , 19 67 , to 4 Sept , 19 67 , that (I) (we) lost saw the deceased alive on 4 Sept , 19 67 , and that death occurred on 1240AM , from causes and on the date stated above.			
22a. SIGNATURE X [Signature]		22b. DATE SIGNED 4 SEPT 67	
22c. PHYSICIAN'S NAME (Type) XXXXXXXXXX A.E. TOMPKINS		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Earlham Cemetery	23d. LOCATION (City or Town) (County) (State) Richmond, Indiana
24. FUNERAL DIRECTOR R.A. Humphrey (For Richmond, Indiana)		25a. REC'D BY REGISTRAR SEP 8 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

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... (for information, Indiana) ...

Violence and Crime, 1990

Richard, Thomas

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 42 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 2610 Weller Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Montgomery Earle HIGGINS				4. DATE OF DEATH Month Day Year September 28 19 67			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 29 1879		9. AGE (In years last birthday) yrs. 87	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Armed Forces		11. BIRTHPLACE (County & State, or foreign country) Sir Johns Run, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James L. HIGGINS				14. MOTHER'S MAIDEN NAME Alice Cross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I & II		16. SOCIAL SECURITY NO. 579-46-9922-A		17. INFORMANT 2610 Weller Rd. Montgomery Higgins Wheaton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pulmonary Edema DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 Aug 67 , 19 67 , to 28 Sep , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 28 Sept , 19 67 , and that death occurred at 12:59P from causes and on the date stated above.							
22a. SIGNATURE Lawrence W. Raymond				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Lawrence W. Raymond, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/67		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Joseph Gawler & Sons				ADDRESS 5130 Wisconsin Ave., Washington, D. C.		25a. REC'D BY REGISTRAR OCT 3 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton			c. LENGTH OF STAY IN lb 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				d. STREET ADDRESS 11200 Lockwood Dr., Apt. 608		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lorna Middle Mae Last Hill				4. DATE OF DEATH Month 9 Day 16 Year 19 67			
5. SEX Female		6. COLOR OR RACE Caus.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1891	
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Bearaboo, Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Young				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-12-1614		17. INFORMANT Mr. Lawrence Hill Address 11200 Lockwood Drive Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis - generalized DUE TO (b) Carcinoma paraneoplastic DUE TO (c) Senilis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 6 mos. 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to 9/16 , 19 67 , that (I) (we) last saw the deceased alive on 9/15 , 19 67 , and that death occurred at 6:42 PM , from causes and on the date stated above.							
22a. SIGNATURE Harry N. Carlton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/16/67	
22c. PHYSICIAN'S NAME (Type) HARRY N. CARLTON, MD				22d. ADDRESS 8811 Colosville Rd, S.S. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR J. B. Thomas ADDRESS 8434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR DATE SEP 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13333

RECEIVED OF LEAD

13333

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "OF LEAD" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12628

CERTIFICATE OF DEATH

12637

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Break Grove Foundation (SHARON)</u>		d. STREET ADDRESS <u>16725 44th Ave -</u>	
5. NAME OF DECEASED (Type or print) <u>Moultrie</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Augusta, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Woolfork</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-8-2618</u>	
17. INFORMANT <u>Jonnie Hitt, Wife</u>		Address <u>Same as Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (b) <u>Atherosclerosis</u> DUE TO <u>Atherosclerosis</u> (c) <u>Atherosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>6-2</u> , 19 <u>67</u> to <u>8-25</u> , 19 <u>67</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>8-24 1967</u> , and that death occurred at <u>7:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Burton A. Johnson</u>		22b. DATE SIGNED <u>9-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Burton A. Johnson</u>		22d. ADDRESS <u>11358 Cherry Hill Rd, Beltsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Magnolia Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Augusta Georgia</u>
24. FUNERAL DIRECTOR <u>GASCH'S</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		25c. ADDRESS <u>HYATTSVILLE, MARYLAND</u>	

1883

RECEIVED

[Faint, mostly illegible handwritten text, possibly a letter or report.]

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[Faint, mostly illegible handwritten text, possibly a letter or report.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12630

CERTIFICATE OF DEATH

12639

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NEW YORK b. COUNTY 69-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AURORA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRLAND NURSING HOME		d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) TEMPLE RICE HOLLCROFT First Middle Last		4. DATE OF DEATH SEPT 1 1967 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-89 9. AGE (In years lost birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HISTORIAN		10b. KIND OF BUSINESS OR INDUSTRY PROFESSOR	
11. BIRTHPLACE (County & State, or foreign country) ALTON, IND.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN TIPTON HOLLCROFT		14. MOTHER'S MAIDEN NAME CLARA Beckin PAUGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES W. W. I		16. SOCIAL SECURITY NO. 111-24-8117A	
17. INFORMANT COPIED FROM CHART AT NURSING HOME Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 ACUTE BRONCHO PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE & KRS.		INTERVAL BETWEEN ONSET AND DEATH DAYS DAYS X KRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from AUG 27, 1967 to SEPT 1, 1967 , that (I) (we) last saw the deceased alive on SEPT. 1 1967 , and that death occurred at 9P M, from causes and on the date stated above.			
22a. SIGNATURE Albert H. Grollman M.D.		22b. DATE SIGNED 9/1/67	
22c. PHYSICIAN'S NAME (Type) ALBERT H. GROLLMAN		22d. ADDRESS 1106 S PRING ST. SILVER SPRING MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-4-67	
23c. NAME OF CEMETERY OR CREMATORY OAK Glen		23d. LOCATION (City or Town) (County) (State) AURORA, N.Y.	
24. FUNERAL DIRECTOR Joseph Gaudin Sons - Washington D.C. ADDRESS		25a. REC'D BY REGISTRAR SEP 7 1967 25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

1800

DATE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12629

12638

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
c. LENGTH OF STAY IN 1b <u>20 days</u>		d. STREET ADDRESS <u>9417 Colesville Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Joseph Hook</u>		4. DATE OF DEATH <u>9 25 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-97</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Hook</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Ward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-01-1135</u>	
17. INFORMANT <u>Emily B. Hook</u> Address <u>9417 Colesville Rd. S.S.Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma lung</u> DUE TO (c) <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <u>SEPT 5, 1967</u> , to <u>SEPT 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>24 SEPT 1967</u> and that death occurred at <u>2:47 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Morrill C. Quinman Jr.</u>		22b. DATE SIGNED <u>9-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morrill C. Quinman Jr.</u>		22d. ADDRESS <u>831 University Blvd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25d. REC'D BY REGISTRAR <u>SEP 29 1967</u>	
25a. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12631		CERTIFICATE OF DEATH		12640			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>32 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		13-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014</u> <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>39 Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Terri Sue Honeycutt</u>				4. DATE OF DEATH Month Day Year <u>September 15 19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 November 1963</u>		9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>15 19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herbert C. Sonifrank</u>				14. MOTHER'S MAIDEN NAME <u>Gladys Honeycutt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction with perforation and</u> <u>2001</u> DUE TO <u>Intra-abdominal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Lymphosarcoma</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>10 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia; Thrombophlebitis</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>14 August, 1967</u> , to <u>15 Sept., 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>15 September 19 67</u> , and that death occurred at <u>8:35 PM</u> , from causes on and the date stated above.							
22a. SIGNATURE <u>Arthur R. Ugel</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>16 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur R. Ugel, MD</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McKenzie</u>		23d. LOCATION (City or Town) (County) (State) <u>Cooksville, Tenn.</u>			
24. FUNERAL DIRECTOR <u>Bozinger 389 Rt. 1, Cranesville, Pa.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

REPORT OF WORK



INTERVIEW WITH ...
DATE ...

REPORT OF WORK



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12641

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
c. LENGTH OF STAY IN lb <u>3 1/2</u>		d. STREET ADDRESS <u>3714 Cardliff Court</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kate Elgin Howard</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 26 1884</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William M. Elgin</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>A. Allen Howard - Husband</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arterio Sclerosis - Generalized</u> DUE TO (c) <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3-1 1/2</u> Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Bell</u> M.D.		22. DATE SIGNED <u>9/24/67</u>	
EXAMINER'S NAME (Type) <u>John S. Bell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Removal</u>	<u>9-26-1967</u>	<u>Nat'l. Memorial Park</u>	<u>Fairfax, Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12633

12642

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 2 mths.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington,			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12921 Old Columbia Pike				d. STREET ADDRESS 1805 Monroe St., N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUY Middle LESLIE Last HOYME				4. DATE OF DEATH Month Sept. Day 4 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13 1873	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Culpeper, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Wm. St. Hoyme				14. MOTHER'S MAIDEN NAME Charlotte E. Cooper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Dr. Lucile E. St. Hoyme 1805 Monroe N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism. 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Four Months years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John S. Rogers				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 9-5-67	
EXAMINER'S NAME (Type) JOHN S. ROGERS				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City, town or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR Arthur Walter 754 Canal St. N.W. Wash. D.C.				25a. REC'D BY REGISTRAR SEP 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

12634

CERTIFICATE OF DEATH

12643

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 909 Lewis Ave.		d. STREET ADDRESS 909 Lewis Ave.	
3. NAME OF DECEASED (Type or print) First HINDA Middle V. Last HUDSON		4. DATE OF DEATH Month September Day 25 , Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1915
9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR: Months 8 Days 4 Hours Min. IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred L. Fraley		14. MOTHER'S MAIDEN NAME Dorothy Kinney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-48-5066	
17. INFORMANT Maynard Hudson - husband - same item #2		Address 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of breast DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 years 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1953 , 19 , to Sept. 25, 1967 , that (I) (we) last saw the deceased alive on Sept. 25, 1967 , and that death occurred at 6:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>William G. Hall</i> M.D.		22b. DATE SIGNED 9/26/67	
22c. PHYSICIAN'S NAME (Type) William G. Hall		22d. ADDRESS 615 W. Montgomery Ave., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/28/67	23c. NAME OF CEMETERY OR CREMATORY St. Mary's	23d. LOCATION (City or town) (County) (State) Rockville Montg. Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR DATE SEP 29 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF NEW YORK

IN SENATE

January 1, 1902

REPORT

OF THE

COMMISSIONER

OF THE LAND OFFICE

FOR THE YEAR 1901

ALBANY:

WILEY

AND SON, PRINTERS

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DEPARTMENT OF THE LAND OFFICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12644

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA RURAL		c. LENGTH OF STAY IN 1b 24 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VIENNA		83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US NAVAL				d. STREET ADDRESS 126 PATRICK ST., SOUTHEAST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle A Last HULL				4. DATE OF DEATH Month SEPT. Day 16 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 FE. 1929	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) SULLIVAN CITY, TENNESSEE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABNER BREWER				14. MOTHER'S MAIDEN NAME ELIZABETH PATRICK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 414347495		17. INFORMANT ROBERT S. HULL		Address 126 PATRICK ST. S.E. APT. 260 VIENNA, VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CIRRHOSIS OF LIVER DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from 23 AUG. 1967 , to 16 SEPT. 1967 , that (we) last saw the deceased alive on 16 SEPT. 1967 , and that death occurred at 4:20AM , from causes on and on the date stated above.							
22a. SIGNATURE C. S. CRUMMY, MD		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 16 SEPT 1967			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9-19-67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L		23d. LOCATION (City or Town) (County) (State) ARLINGTON FAIRFAX VA.			
24. FUNERAL DIRECTOR R. A. PUMPHREY ADDRESS 7557 WISCONSIN AVE, BETHESDA, MD.				25a. REC'D BY REGISTRAR DATE SEP 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day 19 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sicklerson</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Route # 2</u>		151	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>L</u> Last <u>Hunt</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/30/196</u>		9. AGE (in years lost birthday) yrs. <u>7</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Baber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Howard Hunt - son - same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis - Acute</u> DUE TO (b) <u>Ruptured Diverticulum of Bladder</u> DUE TO (c) <u>Prostatic Hypertrophy with obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		7936 Old Georgetown Road		Bethesda, Md.		22. DATE SIGNED <u>10/1/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		23d. LOCATION (City or Town) (County) (State) <u>Monocacy, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		Rockville, Md.		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

W. W. Chapman
Robert & Sons
3/30/90
Chapman
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3/30/90
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

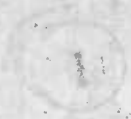
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20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12637						12646					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Montgomery			Belted			MD			Beeching		
c. LENGTH OF STAY IN b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
21 days			Suburban			75-2			239 Mylin St.		
3. NAME OF DECEASED (Type or print)			First Middle Last			DATE OF DEATH			Month Day Year		
Harry			Hunter			Sept 14 1967			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days	
Male		Negro				10/22/1902		64		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Manager				Sentry Concession				Key West, Fla.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Bertram James Hunter						Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
no						204-01-1579					
17. INFORMANT						Address					
no						Bertha Hunter - 239 Mylin St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
331X Cerebral Hemorrhage											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
Hypertensive Cardiovascular Disease											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 8-24-1967 to 9-14-67 that (I) (we) last saw the deceased alive on 9-13-1967, and that death occurred at 7:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
22e. REC'D BY REGISTRAR											
22f. REGISTRAR'S SIGNATURE											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											

35048

STATE OF CALIFORNIA

1881



SEP 1 1881

12638

CERTIFICATE OF DEATH

12647

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>2-WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>2828 RADIUS ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RALPH</u> First <u>Milton</u> Middle <u>HURLEY</u> Last				4. DATE OF DEATH Month <u>9</u> - Day <u>6</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/15</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Post Office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Walter Hurley</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Berry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-3601</u>		17. INFORMANT <u>Mary Hurley 2828 Radium Rd., Wheaton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>14 d.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> , 19 <u>67</u> , to <u>9/6</u> , 19 <u>67</u> that (I) (we) saw the deceased alive on <u>9/6</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>William J. Aud</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William J. Aud, M.D.</u>				22d. ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>	
24. FUNERAL DIRECTOR <u>John S. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Case cleared - Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12639

CERTIFICATE OF DEATH

12648

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb DOA	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 14207 Chadwick Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lena		4. DATE OF DEATH Month September Day 26 Year 19 67	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/18/95	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 26 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Feldman		14. MOTHER'S MAIDEN NAME Rebecca	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Daughter, Mrs. Beatrice Spear		Address 14207 Chadwick Ln Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) AECVD DUE TO (c) 7 years.		INTERVAL BETWEEN ONSET AND DEATH approx 30 mins	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 to Sept. 26, 1967 , that (I) (we) last saw the deceased alive on Sept. 24, 1967 , and that death occurred at 7:37 P.M. from causes on and the date stated above.			
22a. SIGNATURE Gene U. Cohen M.D.		22b. DATE SIGNED Sept 26. 67	
22c. PHYSICIAN'S NAME (Type) Dr. Gene U. Cohen		22d. ADDRESS 1106 Spring St. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/67	
23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Quincy Funeral Home 3501 14th St NW		25a. REC'D BY REGISTRAR SEP 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12248

STANDARD OF LITERATURE

12248

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1100 S. 1st St. Silver Spring, Md.

Dr. J. V. Cannon

1100 S. 1st St. Silver Spring, Md.

SEP 20 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12640

12649

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		d. STREET ADDRESS 2611 BLUERIDGE AVE.	
3. NAME OF DECEASED (Type or print) PETER William JACKSON		4. DATE OF DEATH Month 9 Day 16 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-31-22
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10b. KIND OF BUSINESS OR INDUSTRY Photography	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jackson		14. MOTHER'S MAIDEN NAME Elsbet Pirie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 217-28-2083	
17. INFORMANT Mrs. Eileen Yates		Address 3810 Wexford Drive Kensington, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1530 IMMEDIATE CAUSE (a) Carcinoma of esophagus DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from January, 1967, to Sept 16, 1967 , that (I) (we) last saw the deceased alive on Sept 16, 1967 , and that death occurred at 12:15 PM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 9/16/1967	
22c. PHYSICIAN'S NAME (Type) BLAINE H. ETG		22d. ADDRESS 2641 Coleridge Rd Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Sept. 18, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory	23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Maryland
24. FUNERAL DIRECTOR J. B. Thomas		25a. REC'D BY REGISTRAR Charles Judge	
Address Warner E. Humphrey, Inc. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

12040

CERTIFICATE OF DATA

12040

DATE OF COLLECTION: 12-1-68

LOCATION: 12-1-68

TIME OF COLLECTION: 12-1-68

NAME OF COLLECTOR: 12-1-68

NAME OF INSTITUTION: 12-1-68

NAME OF PROJECT: 12-1-68

NAME OF FUNDING AGENCY: 12-1-68

NAME OF PI: 12-1-68

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY COUNTY, MARYLAND				MONTGOMERY COUNTY, MARYLAND			
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN tb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		83.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 2915 Landover Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Teresa L. JACKSON				4. DATE OF DEATH Month September Day 8 Year 1967			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 MAY 1965	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Wright-Patt AFB Dayton, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aubrey G. JACKSON				14. MOTHER'S MAIDEN NAME Elsie BREWER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Aubrey G. JACKSON 2915 Landover St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4343 IMMEDIATE CAUSE (a) Constrictive Pericarditis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that NO (this hospital) attended the deceased from 6 Sep , 1967, to 8 Sep , 1967, that NO (we) last saw the deceased alive on 8 Sep , 1967, and that death occurred at 1:55 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Eugene D. Van Hove</i> M.D.				22b. DATE SIGNED 9 Sep 1967			
22c. PHYSICIAN'S NAME (Type) E. D. VAN HOVE LCDR MC USN				22d. ADDRESS U.S. Naval Hospitl, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12 Sep 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) _____ (County) _____ (State) Virginia				
24. FUNERAL DIRECTOR IVES FUNERAL HOME 2847 Wilson Blvd. Arlington, Virginia			25a. REC'D BY REGISTRAR SEP 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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2 MAY 1965

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U.S. Naval Hospital, Washington, D.C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12642

12651

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASHINGTON DC</u> b. COUNTY <u>WASHINGTON DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>5036 FULTON ST N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID FRANCIS JAMIESON</u>		4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 4, 1901</u>
9. AGE (In years lost birthday) yrs. <u>63</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARTOGRAPHIC ENGINEER - Maps Dept. AAA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, DC</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, DC</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JOHN YOUNG JAMIESON</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE EVANS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW#2</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Catherine Jamieson</u>		Address <u>5036 Fulton N.W. Washington DC</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis. Acute</u> DUE TO (b) <u>Cardio Vascular Disease -</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u> </u> at work <u> </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Bold</u> M.D.		22. DATE SIGNED <u>9/25/67</u>	
EXAMINER'S NAME (Type) <u>John S. Bold</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u> </u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>9/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>The S. H. Hines Company</u>	
24a. REC'D BY REGISTRAR <u>SEP 27 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12643

CERTIFICATE OF DEATH

12652

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Virginia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>299 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. STREET ADDRESS <u>3822 Ingalls Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Diane</u> Last <u>Jessie</u>		4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 August 1957</u>
9. AGE (In years last birthday) <u>10</u> yrs.		10. IF UNDER 1 YEAR Months <u>13</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawrence D. Jessie</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Giles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		18. ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>299X</u> IMMEDIATE CAUSE (a) <u>Atelectasis and pneumonia</u> DUE TO (b) <u>Undiagnosed disease characterized by</u> weakness, hypomagnesemia (c) <u>7 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 18, 1966</u> to <u>September, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 13, 1967</u> , and that death occurred at <u>5:25 M.</u> from causes on and the date stated above.			
22a. SIGNATURE <u>Paul W. Hathaway</u>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>14 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Paul W. Hathaway, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Sept. 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Concord Meth. Church Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Chatham, Va.</u>
24. FUNERAL DIRECTOR <u>Everly-Wheatley Funeral Home, Alex., Va.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 18 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1953

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

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Case discussed with acting coroner (Dr. Ball) and closed.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G392 8/19/67 ph

CERTIFICATE OF DEATH

12653

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
c. LENGTH OF STAY IN lb <i>16 days</i>		d. STREET ADDRESS <i>3505 - 43rd ave</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Resmore Sanitarium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Albrian T. Johnson</i>		4. DATE OF DEATH <i>Sept 8 1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years) <i>65</i> (lost birthday) <i>66</i> yrs.
9. B. DATE OF BIRTH <i>Sept 9, 1901</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lockwood Dental Lab.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Nora Wilson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes WWII</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Susan C. Muschlitz (above a d)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia</i> (Sister) dress) <i>5 months</i> DUE TO (b) <i>Bronchogenic carcinoma</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic alcoholism, ureteropyelostomy - cecostomy</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>8:30 a.m.</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8/23</i> , 1967, to <i>9/8</i> , 1967, that (I) (we) last saw the deceased alive on <i>8/31</i> , 1967, and that death occurred at <i>9:00 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Allen J. Neill</i>		22b. DATE SIGNED <i>9/8/1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		22d. ADDRESS <i>8601 old Georgetown Rd</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9/12/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ivy Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Upperville, Va.</i>
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>		25. REC'D BY REGISTRAR <i>SEP 15 1967</i>	
ADDRESS <i>Mt. Rainier Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

Protophagus carolinensis

Protophagus carolinensis
16 days Hypocentrus
Albino T. Johnson
male white
X

Protophagus carolinensis
3502-43rd Ave
Sept 8, 1901
X

Protophagus carolinensis
Rockwood Dental
X

Protophagus carolinensis
Virginia
X

Protophagus carolinensis
Allen J. O'Brien
X

Protophagus carolinensis
Allen J. O'Brien
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #3 Box 252		d. STREET ADDRESS RFD #3 Box 252	
3. NAME OF DECEASED (Type or print) Elmer A. Johnson		4. DATE OF DEATH Month September Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 3, 1898
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Digger		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. Johnson		14. MOTHER'S MAIDEN NAME Laura A. Foster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 441-03-0764	
17. INFORMANT Richard N. Johnson- same item #2 -Son		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 3 hours		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957 , 19 57 , to Present , that (I) (we) last saw the deceased alive on Apr. 16, 1967 , and that death occurred on 29 M, from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED 9-30-67	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher		22d. ADDRESS 105 Russel Ave., Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 10/4/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Prince George Md
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR ACT 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12646						12655					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Montgomery			Wheaton			D.C.					
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
2 1/2 mos.			University Nursing Home, 901 Arcola Rd.			Washington			1414 Saratoga Ave. N.E.		
e. IS RESIDENCE ON A FARM?			f. DATE OF DEATH			g. DATE OF BIRTH			h. AGE (In years last birthday)		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Sept. 25 1967			7/1/1879			88 yrs.		
i. NAME OF DECEASED (Type or print)			j. SEX			k. COLOR OR RACE			l. MARRIED		
Gershom			Male			Wh.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			n. KIND OF BUSINESS OR INDUSTRY			o. BIRTHPLACE (County & State, or foreign country)			p. CITIZEN OF WHAT COUNTRY?		
Ret.- Auditor			U.S. Gov't.			St. Johns, Canada			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
William Johnston						Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.					
No						089-14-49356					
17. INFORMANT						Address					
Fanny G. Johnston, Wife, Sams as #2											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
4221 CVA & acute Congestive failure											
Cerebral Thrombosis											
DUE TO (b)											
DUE TO (c)											
AscVD & Cerebral Vasc Disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
Urinary Infection											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
Hour a.m. p.m.											
20d. INJURY OCCURRED											
While <input type="checkbox"/> Not While <input type="checkbox"/>											
at work at work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Aug 1967, to Sept 25, 1967, that (I) (we) last saw the deceased alive on Sept 25 19 67, and that death occurred at 4:47 PM, from the causes and on the date stated above.											
22a. SIGNATURE											
Russell C. Bufalino											
22b. DATE SIGNED											
Sept 26, 1967											
22c. PHYSICIAN'S NAME (Type)											
Russell C. Bufalino											
22d. ADDRESS											
1429 Univ. BLVD. W. SILVER SPRING, MD											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
Cremation											
23b. DATE THEREOF											
9/27/67											
23c. NAME OF CEMETERY OR CREMATORY											
Cedar Hill Crematory											
23d. LOCATION (City, town or county) (State)											
Suitland, Md											
24. FUNERAL DIRECTOR											
Joseph Grawlers Sons											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
DATE SEP 28 1967											

1885

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Wm. J. Johnston
Clerk & Cashier
Central National Bank
New York City

Joseph Johnston
Russell G. Johnston
1450 Union Blvd. N. W.
Washington, D. C.
April 21
1885

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #236 Film #G392 9/13/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS Route 1, Box 433, Lot 53	
3. NAME OF DECEASED (Type or print) Lorraine Irene JONES		4. DATE OF DEATH Month September Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1934
9. AGE (In years lost birthday) yrs. 33		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A (housewife)	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Drury		14. MOTHER'S MAIDEN NAME Eva Dubroski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Lot 53 Lexington Park, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bilateral pyelonephritis DUE TO (b) Secondary to radiation cystitis with obstruction DUE TO (c) ureteral vesicle junction bilateral. Secondary to carcinoma of cervix	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Aug. 24 , 19 67 , to Sept. 6 , 19 67 , that (X) (we) last saw the deceased alive on Sept. 6 , 19 67 , and that death occurred at 700AM , from causes and on the date stated above.			
22a. SIGNATURE Lawrence A. Jones, M.D.		22b. DATE SIGNED 6 Sept. 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence A. Jones, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park National Cemetery, Baltimore, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Mattingly Funeral Home Leonardtwn, Maryland		25a. REC'D BY REGISTRAR SEP 13 1967 DATE	
25b. REGISTRAR'S SIGNATURE James Judge			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 394
11-14-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12648

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12657

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1830-17 St. N.W. #401</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mitchell S Jones</u>			4. DATE OF DEATH Month Day Year <u>9 10 1967</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-49</u>		9. AGE (In years last birthday) yrs. <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>DC.</u>	
13. FATHER'S NAME <u>Newton Jones</u>			14. MOTHER'S MAIDEN NAME <u>Marjorie Clyburn</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Margaret L. Jones Alexandria Va</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple extreme skull fractures</u> DUE TO (b) <u>incurred in auto accident</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>riding in car involved in auto accident at high rate of speed</u>			
20c. TIME OF INJURY Month, Day, Year <u>3:30 a.m. 9 10 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	
				20f. (City or town) (County) (State) <u>Takoma Park Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>[Signature]</u>		M.D.		22. DATE SIGNED <u>9-10-67</u>	
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 13, 1967</u>	
		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

18057

18057

D.C.

Department of Justice

Washington, D.C.

Mr. J. Edgar Hoover

Director

Dear Sir:

Re:

Letter of March 1, 1957

Re: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Very truly yours,

18057

18057

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 394
11-14-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12649

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12658

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>15 1/2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sam + Hospital</u>				d. STREET ADDRESS <u>14215 London Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Wilene Virginia Jones</u>				4. DATE OF DEATH <u>9 10 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26-49</u> 18 <u>18</u>	
9. AGE (In years last birthday) yrs. <u>18</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Montg. Co. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William R. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Virginia C. Cox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-54-8437</u>		17. INFORMANT Address <u>William R. Jones - Father - same item #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple, extreme fractures of skull</u> <u>824.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>incurred in auto accident</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Falling in car, in auto accident, 28 high volts of speed</u>			
20c. TIME OF INJURY Month, Day, Year <u>9-10 1967</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>				20f. (City or town) <u>Takoma Park</u> (County) <u>Montg.</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.				22. DATE SIGNED <u>9-10-67</u>			
EXAMINER'S NAME (Type) <u>John S. Rogers</u>				Address (Street, city, town, or county) <u>1919 Seminary Rd, S.W. 521. 521. 521. 521.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				ADDRESS <u>1331 Rock Pike Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

12228

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE
SECRETARY

Washington, D. C., January 1, 1917

Dear Sir:

Very truly yours,

Enclosed for you are two copies of the report of the

Commissioner of the General Land Office, dated January 1, 1917,

concerning the proposed sale of the public lands in the

State of California, and the report of the

Commissioner of the General Land Office, dated January 1, 1917,

concerning the proposed sale of the public lands in the

State of California, and the report of the

Commissioner of the General Land Office, dated January 1, 1917,

concerning the proposed sale of the public lands in the

State of California, and the report of the

Commissioner of the General Land Office, dated January 1, 1917,

concerning the proposed sale of the public lands in the

State of California, and the report of the

Commissioner of the General Land Office, dated January 1, 1917,

concerning the proposed sale of the public lands in the

State of California, and the report of the

Commissioner of the General Land Office, dated January 1, 1917,

concerning the proposed sale of the public lands in the

State of California, and the report of the

CERTIFICATE OF DEATH

12650

12659

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>53 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014 The Clinical Center, Bethesda, Maryland</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Michigan</u> b. COUNTY <u>Mason</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ludington</u> d. STREET ADDRESS <u>Route 2, Dicker Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>(NMN)</u> Last <u>Jorgensen</u>			4. DATE OF DEATH Month <u>September</u> Day <u>8</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 May 1908</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Pilot) American Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Hans Jorgensen</u>			14. MOTHER'S MAIDEN NAME <u>Anna Kundsén</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>711-01-8379</u>	17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Soft Tissue & Probable bone infection</u> DUE TO <u>Blast crisis</u> (c) <u>Chronic Myelogenous Leukemia/</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>5 Days</u> <u>50 Days</u> <u>2 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>17 July</u> , 19 <u>67</u> , to <u>8 September</u> 19 <u>67</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>8 September 1967</u> , and that death occurred at <u>6:30M</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Ch Haskell MD</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>8 Sept. 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Charles M. Haskell, MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>Burial-transit 9-9-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Ludington, Michigan</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15888

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12660

12651

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>16 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SAN + HOSPITAL</u>				d. STREET ADDRESS <u>8013 TAKOMA AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN LEO JUNG HANS</u>				4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1893</u>		9. AGE (In years last birthday) yrs. <u>73</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED, Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK JUNG HANS</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET Spain.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>ARMY WWI</u>		16. SOCIAL SECURITY NO. <u>578-07-9380</u>		17. INFORMANT <u>Chaut</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents</u> DUE TO (b) <u>Gastrointestinal bleeding</u> DUE TO (c) <u>Carcinoma of the stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-23</u> , 19 <u>67</u> , to <u>9-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-23</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>B. G. Bendler</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. G. Bendler</u>				22d. ADDRESS <u>10820 Ga. Ave, Wheaton, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Wheaton, Md.</u>	
24. FUNERAL DIRECTOR <u>W.C. Chambers Inc.</u>				ADDRESS <u>8655 Ga. Ave Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY in 1b 46 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALMA First GERTRUDE Middle KELBAUGH Last		4. DATE OF DEATH Month SEPT Day 13 Year 19 67	
5. SEX FE	6. COLOR OR RACE WH	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/03
9. AGE (In years lost birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES E. THIRLES		14. MOTHER'S MAIDEN NAME MARY GUNDLING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 578-05-1304	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Cardiovascular Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RT lobar pneumonia			INTERVAL BETWEEN ONSET AND DEATH 8 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-1-67 , 19 67 , that (I) (we) lost saw the deceased alive on 9-13-67 , and that death occurred at 1030 AM , from causes and on the date stated above.			
22a. SIGNATURE James E. Thirles		22b. DATE SIGNED 9-14-67	
22c. PHYSICIAN'S NAME (Type) James E. Thirles		22d. ADDRESS 7711 Carroll Ave Takoma Park Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Whitfield Cemetery	23d. LOCATION (City or Town) (County) (State) Lanham Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR SEP 19 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

10881

UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12653

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12662

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>2 1/2 MOS.</u>		d. STREET ADDRESS <u>1506 Gridley Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1506 Gridley Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOVELLA M. KELLER</u>		4. DATE OF DEATH <u>9-26-67</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 18, 1909</u>
9. AGE (In years, last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>9</u> Days <u>26</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN WM. RUSH</u>		14. MOTHER'S MAIDEN NAME <u>MARY CAMPBELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>WALTER RUSH, (BROTHER)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO (b) _____ DUE TO (c) <u>Coronary artery heart disease</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Heap</u> M.D.		22. DATE SIGNED <u>9-26-1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. HEAP M.D.</u>		23. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 2, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> ADDRESS <u>8434 Georgia Ave.</u>		25a. REC'D BY REGISTRAR <u>Charles Yunge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Yunge</u>		DATE <u>OCT 2 1967</u>	

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WORLD CHAMPIONSHIP CHAMPIONSHIP

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12663

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul Leslie Kelley</u>		4. DATE OF DEATH <u>9</u> Month <u>1</u> Day <u>1967</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-19</u> 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Customs Officer U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Leslie Kelley</u>		14. MOTHER'S MARRIED NAME <u>Marguerite Penn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-14-5110</u>	
		17. INFORMANT <u>Georgetta B. Kelley</u> Address <u>K.P.K. Md. 7513-Jackson Ave.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>970.2</u> IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u> DUE TO (b) <u>Overdose of barbiturates</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Took overdose of sleeping pills</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:00</u> <u>Sept 1</u> <u>1967</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Takoma Park</u> <u>Montg.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>9/2/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 7, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>C. J. Carter</u> <u>8434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any return is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

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OFFICE OF THE ATTORNEY GENERAL
WASHINGTON, D.C. 20530

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U.S. DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
WASHINGTON, D.C. 20530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12655		12664	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooke Grove Foundation</u> 151	
c. LENGTH OF STAY IN lb <u>3 days</u>		d. STREET ADDRESS <u>Olney</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ada Amanda Ker Kow</u>		4. DATE OF DEATH Month Day Year <u>September 9 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-81</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>own home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Denton</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>566-16-0777</u>	
17. INFORMANT <u>Washington Sanitarium-records</u>		Address <u>Takoma Park, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration</u> DUE TO <u>Cardiovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Arteriosclerotic Heart Disease.</u> (b) <u>Arteriosclerotic Heart Disease.</u> (c) <u>Arteriosclerotic Heart Disease.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Sept 6</u> , 19 <u>67</u> , to <u>Sept 9</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>Sept 9</u> , 19 <u>67</u> , and that death occurred at <u>11:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert E. Wilhelm</u>		22b. DATE SIGNED <u>Sept 9, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert E. Wilhelm</u>		22d. ADDRESS <u>Rustonsville Medical Center, Rustonsville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9-12-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
4308 Suitland Rd Suitland Maryland		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12804

TESTAMENT OF DEATH

12804

County

State

Brooks Grove Foundation

Diney

September 19

Witness

Notary

Garret Hill Cemetery

Exemption 1-1-1987

Robert H. Wilber - Personal Home

1200 S. 12th St. Lincoln, Nebraska

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

<div>12656</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>12665</div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>mont.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 15 <u>8 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>						d. STREET ADDRESS <u>1901 Dayton St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara B Kern</u>						4. DATE OF DEATH Month <u>Sept</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-11-1883</u>		9. AGE (In years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Bowman</u>						14. MOTHER'S MAIDEN NAME <u>Allie J. Stogner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-56-7481-T</u>		17. INFORMANT Address <u>Mr. Cecil Kern 1901 Dayton St. S. S., Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT (THROMBOSIS)</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) RECURRENT INTERMITTENT ONSET AND DEATH INTERVAL BETWEEN ONSET AND DEATH <u>INDEFINITE</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>RIGHT POST-OP STATUS (12/66), REDUCTION INTER-TROCHANTERIC FRACTURE</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/19/66</u> to <u>9/13/1967</u> , that (I) (we) last saw the deceased alive on <u>9/13/1967</u> and that death occurred at <u>4:35 A</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Lawrence D. Marcus</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/5/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE D. MARCUS, M.D.</u>						22d. ADDRESS <u>1111 SPRING STREET, SILVER SPRING, MD 20910</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>Sept. 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Crematory</u>				23d. LOCATION (City or Town) (County) (State) <u>3201 Bladensburg Rd. D.C.</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Pumphrey Inc. 8434 Georgia Ave S.S. Md</u>						25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1888

DEPARTMENT OF AGRICULTURE

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SEP 8 1888

SEP 8 1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12657

CERTIFICATE OF DEATH

12666

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
				JAKOMA PARK			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL				d. STREET ADDRESS 7113 WOODLAND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUSSELL Middle G. Last KILBY				4. DATE OF DEATH Month SEPT Day 26 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-07	9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (County & State, or foreign country) Culpeper Co. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Juber Kilby				14. MOTHER'S MAIDEN NAME Lela Sherman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 224-28-1171		17. INFORMANT Address 7113 Woodland Ave. Tacoma, Md. Russell G. Kilby Jr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) CARCINOMA OF LUNG METASTASIS DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 5 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RT. PNEUMONECTOMY WITH THORACOTOMY 1962				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 9/19 , 19 67 to 9/26 , 19 67 that (I) (we) last saw the deceased alive on 9/26 , 19 67 , and that death occurred at 7:30 M, from causes on and on the date stated above.							
22a. SIGNATURE David Goldenberg				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/26/67	
22c. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG				22d. ADDRESS 10620 GEORGIA SILVER SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9/30/67		23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City or Town) (County) (State) Culpeper, Culpeper Va.	
24. FUNERAL DIRECTOR Charles G. Loebl				ADDRESS Culpeper, Va.		25a. REC'D BY REGISTRAR OCT 2 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

12668

DATE OF BIRTH

1925

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12658

12667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>1 Year 5 Mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1 d. STREET ADDRESS <u>8109 Fenton Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma D. Kilgore</u>			4. DATE OF DEATH Month Day Year <u>September 24 19 67</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1878</u>		9. AGE (In years last birthday) yrs. <u>88</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>			
13. FATHER'S NAME <u>John Siders</u>			14. MOTHER'S MAIDEN NAME <u>Mary J. Derr</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-50-1784</u>		17. INFORMANT Address <u>Roy J. Kilgore-10101 Phoebe Lane, Adelphi, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BR. PNEUMONIA</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY CONGESTION</u> DUE TO (c) <u>ARTERIO-SCLEROTIC CARDIO-VASC. DIS.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>5 WEEK</u> <u>2 wks</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 9, 1963</u> , to <u>9/24/67</u> , that (I) (we) last saw the deceased alive on <u>9/22</u> , 1967, and that death occurred at <u>12:25</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>R.S. Williams</u> M.D.			22b. DATE SIGNED <u>9/24/67</u>		22c. PHYSICIAN'S NAME (Type) <u>R.S. WILLIAMS</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>			23b. DATE THEREOF <u>Sept. 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rolling Creek Cemetery</u>		
23d. LOCATION (City or Town) (County) (State) <u>Camp Hill, Pennsylvania</u>			24. FUNERAL DIRECTOR <u>Cecil G. Carter</u> ADDRESS <u>48434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Maryland</u>				
25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

73

12-21-57

22

7-10-52

1952

1021

12668

12659

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY -----	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47.3	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Apt 302</u> <u>1401 Oglethorpe St N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitorium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Abraham NMN Kreuter</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-01</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Sigmund Kreuter</u>		14. MOTHER'S MAIDEN NAME <u>Esther Klinkenstein</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>062-05-3567</u>	
17. INFORMANT <u>Patient's chart.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 420.1 DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>pulmonary emboli suspected</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> , 19 <u>67</u> to <u>9-28</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9-28</u> 19 <u>67</u> and that death occurred at <u>2:05</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Gilbert B. Cushner</u> M.D.		22b. DATE SIGNED <u>9-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gilbert B. Cushner</u>		22d. ADDRESS <u>11161 New Hampshire Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-29-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beth David Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Elmont, L. I., New York</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>ACT 2</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
ADDRESS <u>4217 9th Street N.W.</u>		DATE <u>9-28-67</u>	

15288

UNITED STATES DEPARTMENT OF THE INTERIOR

CERTIFICATE OF DEATH

John Doe
Age 45
Born 12/15/1901

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

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John Doe

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12660

12669

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8715 Hempstead Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Henry Frederick Krueger</u>		4. DATE OF DEATH <u>9-3-67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Ill. Cook Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry L. Krueger</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Krueger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army.</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute-</u> <u>4201</u> DUE TO (b) <u>Cardio Vascular Disease-</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/3/67</u>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9/5/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Geo. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12338

RECEIVED

1

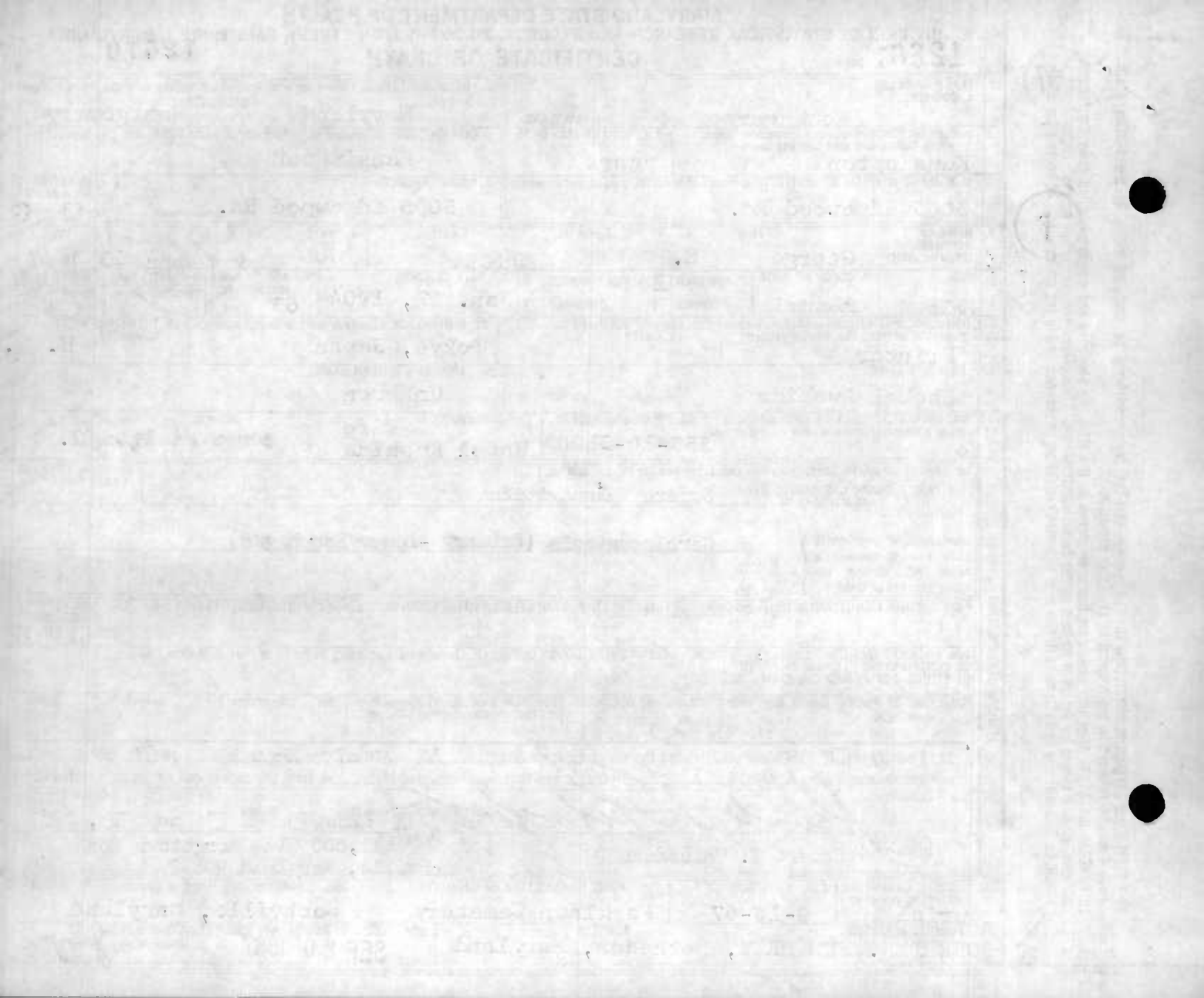


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3005 Edgewood Rd.</u>					d. STREET ADDRESS <u>3005 Edgewood Rd.</u>				
3. NAME OF DECEASED (Type or print) <u>George S. KUSHIDA</u>					4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Oriental</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 27, 1904</u>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Tokyo, Japan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Shobel Kushida</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>55-10-5100A</u>		17. INFORMANT <u>Wife</u> <u>Hazel Kushida</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Malnutrition</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Carcinomatosis (Primary *Lower Esophagus)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August 12, 1967</u> , to <u>Sept 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 11, 1967</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert T. Thibadeau</u>					22b. DATE SIGNED <u>Sept 13, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau</u>					22d. ADDRESS <u>11,000 Old Georgetown Road</u> <u>Rockville, Maryland 20852</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 20 1967</u>			
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY COUNTY, MARYLAND				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12662				12671			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>one month</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>—</u>				47.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium</u>				d. STREET ADDRESS <u>2252 Nichols Ave. S.E.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Isadore</u> First <u>Kushner</u> Middle Last				4. DATE OF DEATH <u>September 28</u> Month Day Year 19 <u>67</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>March 13, 1913</u>		9. AGE (In years last birthday) yrs. <u>54</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Businessman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor Store Owner</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>MAX Kushner</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca INBINDER</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Joyce K. TROSHINSKY</u>				Address <u>Bethesda, Md. 6300 CARNEGIE DR.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 332 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Decubitus ulcer, sacrum</u> (c) <u>Cerebral Thrombosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, cerebral</u>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>67</u> to <u>Sept 28</u> , 19 <u>67</u> , that (we) last saw the deceased alive on <u>Sept 24</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.															
22a. SIGNATURE <u>Richard Kaufman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>9/28/67</u>							
22c. PHYSICIAN'S NAME (Type) <u>RICHARD KAUFMAN</u>				22d. ADDRESS <u>916 19th ST NW WASH, DC.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9-29-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Lebanon Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>					
24. FUNERAL DIRECTOR <u>B. Danzansky & Sons</u>				ADDRESS <u>3501-14th St NW</u>				25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

1871



1872

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections.]

[Faint, mostly illegible handwritten text along the right margin, possibly a list or notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
12663		CERTIFICATE OF DEATH		12672	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		c. LENGTH OF STAY IN Tb Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1- Buttonwood Lane		d. STREET ADDRESS 1 Buttonwood Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANA First S, Middle Kybal Last		4. DATE OF DEATH 9 Month 28 Day 1967 Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1873	9. AGE (In years last birthday) yrs. 94	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mexico	
13. FATHER'S NAME Francisco Raymundo		12. CITIZEN OF WHAT COUNTRY? Mexico			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 559-70-7883		17. INFORMANT Son Address Same as Item 2. Milic Kybal	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Chronic Pyelonephritis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 Mo Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio-sclerotic heart disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from September 1956 to 9/28 , 1967, that (I) (we) last saw the deceased alive on 9/27 , 1967, and that death occurred at 4:30 AM , from causes and on the date stated above.					
22a. SIGNATURE J. A. K. P. Segal		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/28/67	
22c. PHYSICIAN'S NAME (Type) J A-K P. Segal		22d. ADDRESS 5323 Conn. Ave NW Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-29-67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DA OCT 2 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

12837

RECORDS OF DATA

12837

TO K P

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Uranium

Chemical Properties

Antineutrino

2000 1/2 P

1/2 P

1/2 P

2000 1/2 P

2000 1/2 P

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12664

12673

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>New York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>136 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>14 Monroe Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Argie</u> First <u>(NMN)</u> Middle <u>Lagouras</u> Last				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 August 1939</u>		9. AGE (In years last birthday) <u>28</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Lagouras</u>				14. MOTHER'S MAIDEN NAME <u>Patra Chakides</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>059-32-0511</u>		17. INFORMANT <u>The Medical Records,</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia, terminal aspiration</u> DUE TO (b) <u>Malignant carcinoid syndrome with extensive metastatic involvement</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> 199.2							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>21</u>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 8, 1967</u> , to <u>September 19, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>September 21, 1967</u> , and that death occurred at <u>10:10 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert I. Keimowitz, MD</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>22 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert I. Keimowitz, MD</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CYPRESS HILL CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>BROOKLYN NEW YORK</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers G 1400 Chapin St NW</u>				25a. REC'D BY REGISTRAR <u>SEP 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13813

RECORD OF DEEDS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12665					12674					
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>16 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>			15-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>					d. STREET ADDRESS <u>7520 Maple Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Amanda</u> Last <u>Lamar</u>					4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-2-88</u>		9. AGE (In years last birthday) <u>79</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. f.</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Negle</u>					14. MOTHER'S MAIDEN NAME <u>Winters</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>24-14-8387</u>		17. INFORMANT <u>Hosp. Record</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>High Blood Pressure</u>									INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/24</u> , 19 <u>67</u> , to <u>9/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/25</u> , 19 <u>67</u> , and that death occurred at <u>10:00</u> AM, from causes and on the date stated above.										
22a. SIGNATURE <u>Alan R. Gair</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>9/25/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>ALAN R. Gair M.D.</u>					22d. ADDRESS <u>7777 Maple Ave, Takoma Park, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. J. Tuckman & Sons</u>					25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

1881

DEPT. OF STATE



1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #4 Film #G393 10/23/67 ph													
12666						12675							
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				15			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS Hosp.						d. STREET ADDRESS 4501 Grenoble Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLAUDE E LANCASTER						4. DATE OF DEATH Month September Day 24 Year 1967							
5. SEX M		6. COLOR OR RACE CAUC		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/21/21		9. AGE (In years, last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKLAYER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) NO. CAROLINA				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Winifred R. Lancaster						14. MOTHER'S MAIDEN NAME Lottie Hudgins							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWII				16. SOCIAL SECURITY NO.		17. INFORMANT Address Anita L. Lancaster- wife - same item #2							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism ss. Acute Card. Tamponade DUE TO (b) Myocardial Infarction & Mural Thrombus. DUE TO (c) Atherosclerosis & Coronary Disease 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Sept. 23, 1967 , to Sept. 24, 1967 , that (I) (we) last saw the deceased alive on Sept 24 1967 , and that death occurred at 7 AM , from causes and on the date stated above.													
22a. SIGNATURE R.C. Bufalino						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept 24, 1967					
22c. PHYSICIAN'S NAME (Type) R.C. Bufalino, M.D.						22d. ADDRESS 1429 Univ. Blvd W. SILVER SPRING, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9/27/67		23c. NAME OF CEMETERY OR CREMATORY Parklawn				23d. LOCATION (City or Town) (County) (State) Rockville Montg. Md.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home						ADDRESS 1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR SEP 27 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #2c Film #G393 10/19/67 ph											
CERTIFICATE OF DEATH											
12667											
12676											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> Wheaton 15.1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						d. STREET ADDRESS <u>8923 Isbell St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eugene F. Langan</u>						4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>Gr</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-24-1917</u>		9. AGE (In years last birthday) yrs. <u>50</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Safety Consultant U.S. Dept. of Army Civ.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Dept. of Army Civ.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward A. Langan</u>						14. MOTHER'S MAIDEN NAME <u>Nellie E. Jones</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1942-1956</u>				16. SOCIAL SECURITY NO. <u>486-16-4100</u>		17. INFORMANT <u>Wife - Mary Ann</u>				Address <u>- Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5271 IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>emphysema</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/1/67</u> , 19 <u> </u> , to <u>Sept 28</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>Sept 27</u> , 19 <u>67</u> , and that death occurred at <u>12:52 AM</u> , from causes on and on the date stated above.											
22a. SIGNATURE <u>Patrick C. Jameson</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/28/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>PATRICK C. JAMESON</u>						22d. ADDRESS <u>11768 Georgia Silver Spring Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR <u>DATE OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1957

OFFICE OF HEALTH

RECEIVED

1957

1957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12677

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DDA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Bartholomew School</u>		d. STREET ADDRESS <u>6416 Crane Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>Patricia Joseph Hanson</u>		4. DATE OF DEATH <u>Sept. 24 1967</u>	
5. SEX <u>M</u> COLOR OR RACE <u>W</u>		8. DATE OF BIRTH <u>Oct. 16 - 1958</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>8</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Lepore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>6416 Crane Terrace</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation -</u> <u>835.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Caught head in Power window of station Wagon.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:15 p.m. 9/24 1967</u>		20d. INJURY OCCURRED <u>2</u> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Parking lot</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/24/67</u>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 29 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

My dear Mr. Brewster
I have just received your letter of the 11th inst. and am glad to hear from you. I am well and hope these few lines will find you the same. I have not much news to write at present. I am still in the same place and doing the same work. I have not yet had time to write you more fully. I will do so as soon as I have a chance. I am, dear Mr. Brewster, very truly yours,
Wm. Brewster

I have not yet had time to write you more fully. I will do so as soon as I have a chance. I am, dear Mr. Brewster, very truly yours,
Wm. Brewster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12669		12678	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville Rural</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium Bethesda Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALBERT</u> First <u>H.</u> Middle <u>LEITH</u> Last		4. DATE OF DEATH <u>Sept 5 1967</u> Month <u>Sept</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 30, 1884</u> 9. AGE (In years last birthday) <u>83</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Henry Leith</u>	
14. MOTHER'S MAIDEN NAME <u>Jennie Leith</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>2/9-16-31/2</u>	
16. SOCIAL SECURITY NO. <u>219-16-3112</u>		17. INFORMANT <u>Charles Leith, Boyds, Md</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>Pulmonary embolism</u> DUE TO (c) <u>Circulatory stasis and inactivity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>several hours</u> <u>many days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>upper respiratory infection; generalized arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 17</u> , 1967, to <u>Sept 5</u> , 1967, that (I) <u>did not</u> see the deceased alive on <u>Aug 31</u> , 1967, and that death occurred at <u>6:40</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>George H. Mitchell</u>		22b. DATE SIGNED <u>Sept 5, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Middleburg</u>	23d. LOCATION (City or Town) (County) (State) <u>Middleburg Va.</u>
24. FUNERAL DIRECTOR <u>William C. Hilt</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Barnwell Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>SEP 11 1967</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12670

12679

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 1 HOUR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 18600 BROOKE ROAD	
3. NAME OF DECEASED (Type or print) HAROLD DISNEY		4. DATE OF DEATH 9 27 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-12
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN LETHBRIDGE		14. MOTHER'S MAIDEN NAME ANNIE DISNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-36-5309	
17. INFORMANT MEDICAL RECORD DEPT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 4201 (b) Obstruction of anterior posterior coronary artery DUE TO Arteriosclerotic heart disease (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 hrs 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/27 , 19 67 to 9/27 , 19 67 , that (I) (we) last saw the deceased alive on 9/27 , 19 67 , and that death occurred at 9:30 A M, from causes and on the date stated above.			
22a. SIGNATURE C. H. LIGON, M. D.		22b. DATE SIGNED 9-27-67	
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Burtonsville	23d. LOCATION (City or Town) (County) (State) Burtonsville, Maryland
24. FUNERAL DIRECTOR Francis H. Barber Laytonville, Md.		25a. REC'D BY REGISTRAR SEP 29 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

12819

UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
12671					12680					
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b 15-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 16609 Jilrick Street					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 16609 Jilrick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First John Middle Penn Last Lewis			4. DATE OF DEATH Month 9 Day 13 Year 1967							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/14/1882		9. AGE (in years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired from Railroad				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Scranton, Pennsylvania		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William H. Lewis					14. MOTHER'S MAIDEN NAME Mary Powell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 712-14-4370		17. INFORMANT Address Walter Lewis-19 Barteau St. Endwell, N. Y.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 4221 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis 5 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 6 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/10/67 , 19____, to 9/19/67 , 19____, that (I) (we) last saw the deceased alive on 9/19/67 , 19____, and that death occurred at 9:05 AM , from the causes and on the date stated above.										
22a. SIGNATURE A. W. Smith M.D.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/13/67			
22c. PHYSICIAN'S NAME (Type) A.W. SMITH					22d. ADDRESS 13018 GEORGIA AVE WHEATON, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9/14/67		23c. NAME OF CEMETERY OR CREMATORY Laurelwood Cemetery		23d. LOCATION (City, town or county) (State) Stroudsburg, Penna.				
24. FUNERAL DIRECTOR The S.H. Hines Company					ADDRESS Washington, DC		25a. REC'D BY REGISTRAR SEP 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

13820

RECEIVED BY BATH

Montgomery

Reynolds

Montgomery

Boothville

Boothville

1800 11th St

1800 11th St

John

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white

white

Boothville, Pennsylvania

Boothville, Pennsylvania

John Booth

John Booth

18-1-1370 Walter Booth - 18 Boothville, N.Y.

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Boothville, N.Y.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12681

12672

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8315 Brook Lane,				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 8315 Brook Lane, Apt. 706 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Martha Middle Portwood Last Lewis		4. DATE OF DEATH Month September Day 19 Year 1967		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 21, 1900		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY Federal Government		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Powell				14. MOTHER'S MAIDEN NAME Ida Nave				15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 215-46-4935		17. INFORMANT Sister Norma Judd Address Same as Item 2.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3561 Amyotrophic Lateral Sclerosis with Bulbar Involvement. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerosis with Bulbar DUE TO (c) Involvement.		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county) Nicholasville, Kentucky				22. DATE SIGNED 9/21/1967													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-22-67		23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cem.		23d. LOCATION (City, town or county) (State) Nicholasville, Kentucky		24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland											
25a. REC'D BY REGISTRAR SEP 22 1967				25b. REGISTRAR'S SIGNATURE J. Charles Judge																	

1928
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*

2. Age: *45*

3. Sex: *Male*

4. Race: *White*

5. Date of Death: *Jan 15, 1928*

6. Place of Death: *Home*

7. Cause of Death: *Heart Disease*

8. Signature of Medical Examiner: *[Signature]*

9. Date of Examination: *Jan 15, 1928*

10. Location of Examination: *Home*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12673

CERTIFICATE OF DEATH

12682

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ST. MARYS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Lee 20692 d. STREET ADDRESS Drayden Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roger Walter Lewis		4. DATE OF DEATH Month September Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1967
9. AGE (In years last birthday) 1-day		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		12. KIND OF BUSINESS OR INDUSTRY N/A	
13. BIRTHPLACE (County & State, or foreign country) Patuxent River, Md.		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Roger M. Lewis		16. MOTHER'S MAIDEN NAME Linda Y. Foard	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		18. SOCIAL SECURITY NO. N/A	
19. INFORMANT Roger M. Lewis, Drayden Rd., Valley Lee, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Valve Stenosis DUE TO (c) Congenital Heart Dis.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Sept. 15, 1967 , to Sept. 16, 1967 , that he (we) last saw the deceased alive on Sept. 16, 1967 , and that death occurred at 9:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED Sept. 18, 1967	
22c. PHYSICIAN'S NAME (Type) F. X. LOERS.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-20-1967	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Lassahn Funeral Home		25a. REC'D BY REGISTRAR SEP 20 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. REGISTRAR'S SIGNATURE [Signature]	

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12683

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 15.1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hosp		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1401 Bradley Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Shawn Presley Leyda		4. DATE OF DEATH Month September Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/64
9. AGE (In years last birthday) 2 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Child
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James H. Leyda, Jr.		14. MOTHER'S MAIDEN NAME Vivian Brawdy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT James H. Leyda, Jr., Father		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 493x IMMEDIATE CAUSE (a) Sudden Death DUE TO Focal pulmonary atelectasis (b) Pneumonia DUE TO Diffuse interstitial pneumonia (c) Aspiration pneumonia		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hydrocephalus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to Natural , 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Frank Mate Jr.		22b. DATE SIGNED 9/25/67	
22c. PHYSICIAN'S NAME (Type) Frank Mate, Jr.		22d. ADDRESS 50 W. Edmondston Drive, Rock, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/27/67	23c. NAME OF CEMETERY OR CREMATORY Finleyville	23d. LOCATION (City or Town) (County) (State) Finleyville, Pa.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR 1331 Rockville Pike DATE SEP 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION
CLEARED BY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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[illegible]

1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12675

12684

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY 473	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 3801 Conn. Ave. N.W.	
3. NAME OF DECEASED (Type or print) David First S. Middle Liepman Last		4. DATE OF DEATH Month Sept. Day 27 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 61 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jules Liepman		14. MOTHER'S MAIDEN NAME Hattye Wineberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 652-12-4573	
17. INFORMANT Potomac Valley Rest Home'		Address Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 153.3 IMMEDIATE CAUSE (a) Diffuse Carcinomatosis due to DUE TO Carcinoma of the Sigmoid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH one year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Post-rheumatic Valvular Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 1955 to Sept. 1967 , that (I) (we) last saw the deceased alive on Sept. 24, 1967 , and that death occurred at 4 P. M. from causes and on the date stated above.			
22a. SIGNATURE Jerome J. Krick		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jerome J. Krick		22d. ADDRESS 3071 Ordway St., Wash. D.C.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Kensico Cem.	23d. LOCATION (City or Town) (County) (State) Hawthorne N.Y.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR SEP 23 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

Address **1331 Rockville Pike**
Rockville, Md.

1208A

GENERAL INSTRUCTIONS

REMARKS

DATE

TIME

LOCATION

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REMARKS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
25M 1/67

RELEASED BY DR BELDON REAP MEDICAL EXAMINER.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
12676					CERTIFICATE OF DEATH					12685				
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			15-1						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN					d. STREET ADDRESS 8603 BRADMOOR DRIVE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First EDWARD Middle OWEN Last LIKENS					4. DATE OF DEATH Month SEPT Day 17 Year 1967									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 3, 1901		9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED				10b. KIND OF BUSINESS OR INDUSTRY GIFT SHOP		11. BIRTHPLACE (County & State, or foreign country) KENTUCKY				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME G.B. LIKENS					14. MOTHER'S MAIDEN NAME RUTH COMBS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. - - -		17. INFORMANT Address MAE MOUNT LIKENS - WIFE - SAME									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema										INTERVAL BETWEEN ONSET AND DEATH 10 min.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July , 19 63 , to 9-17 , 19 67 , that (I) (we) last saw the deceased alive on 9-8 , 19 67 , and that death occurred at 9:31 A.M. , from causes and on the date stated above.														
22a. SIGNATURE G. F. Sengstack M.D.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-17-67							
22c. PHYSICIAN'S NAME (Type) Dr. G. F. Sengstack					22d. ADDRESS 9241 Columbia Blvd. Silver Md. Sp.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9-18-1967		23c. NAME OF CEMETERY OR CREMATORY Hartford Cemetery			23d. LOCATION (City or Town) (County) (State) Hartford, Ky.							
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.					25a. REC'D BY REGISTRAR SEP 20 1967		25b. REGISTRAR'S SIGNATURE [Signature]							

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STANDARD FORM NO. 64

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CERTIFICATE OF DEATH

12686

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Darnestown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kearneysville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. # 28		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) ANNIE C. LISKEY		4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1967	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1884
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Haycock		14. MOTHER'S MAIDEN NAME Hannah Ellis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 232-74-2726	
17. INFORMANT Gladys Dunn - Item # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April , 1967, to Sept 25 , 1967, that (I) (we) last saw the deceased alive on Sept 25 , 1967, and that death occurred at 9:30 AM , from causes on and on the date stated above.			
22a. SIGNATURE John Fawcett		22b. DATE SIGNED 9/25/67	
22c. PHYSICIAN'S NAME (Type) John Fawcett		22d. ADDRESS Dawsonville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/27/67	23c. NAME OF CEMETERY OR CREMATORY Bakersville	23d. LOCATION (City or Town) (County) (State) Bakersville, Md.
24. FUNERAL DIRECTOR Melvin T. Strider Company Charlestown, W.Va.		25a. REC'D BY REGISTRAR DATE SEP 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES DEPARTMENT OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12678

CERTIFICATE OF DEATH

12687

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Center Street		d. STREET ADDRESS 11 Center Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Howard R. Loeffel		4. DATE OF DEATH September 11, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/86
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Loeffel		14. MOTHER'S MAIDEN NAME Elizabeth Perry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-09-9932	
17. INFORMANT Ethel J. Loeffel - wife - same item "2"		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary Arteriosclerosis (b) Coronary Arteriosclerosis (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 48 hrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Minor		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 66 to 9/11 , 19 67 , that (I) (we) last saw the deceased alive on 9/11 , 19 67 , and that death occurred at 11:45 AM , from causes and on the date stated above.		22a. SIGNATURE Stephen Jones M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED 9/12/67		22c. PHYSICIAN'S NAME (Type) Stephen Jones	
22d. ADDRESS 809 Veirs Mill Road, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/15/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Prince Georges Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. RECORD BY REGISTRAR SEP 13 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

18081

CERTIFICATE OF DEATH

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 Film #G392 9/13/67 ph

12679

CERTIFICATE OF DEATH

12688

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>17 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		15 /	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12609-Conn. Avenue</u>		d. STREET ADDRESS <u>12609-Conn. Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rudolph</u> Middle <u>Frederick</u> Last <u>Lohaus</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893 Aug. 30, 1897</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Lohaus</u>		14. MOTHER'S MAIDEN NAME <u>Lena Hagenberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-48-7118</u>	
17. INFORMANT <u>Loretta Lohaus-wife -12609-Conn. Ave.</u>		Address <u>Kensington, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>5272</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Lung Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>9-3</u> , 1967, that (I) (we) last saw the deceased alive on <u>9-3</u> , 1967, and that death occurred at <u>7:20 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Morris Perry</u>		22b. DATE SIGNED <u>9-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		22d. ADDRESS <u>11602-Ga. Avenue Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 7, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Mayville, Wisconsin</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S. S. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			

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UNITED STATES OF AMERICA

1988

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12680

12689

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>22 days/11 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		473	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium *Hospital</u>		d. STREET ADDRESS <u>2240 Cathedral Ave. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ELKA</u> First Middle Last <u>NMN LORBERBAUM</u>		4. DATE OF DEATH Month Day Year <u>September 12, 1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-18-88</u> Last birthday yrs.	
9. AGE (In years) <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWR</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Palestine</u>		12. CITIZEN OF WHAT COUNTRY? <u>NONE</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Schendel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-6608642</u>	
17. INFORMANT Address <u>Hospital Records 7600 Carroll Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> DUE TO <u>CARDIAC FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>20 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT 7, 1967</u> to <u>SEPT 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>SEPT 11, 1967</u> , and that death occurred at <u>7:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Krichmar</u> M.D.		22b. DATE SIGNED <u>SEPT 12, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT H. KRICHMAR MD</u>		22d. ADDRESS <u>7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20012</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National Capital Hebrew</u>		23d. LOCATION (City or Town) (County) (State) <u>Hillside, Maryland.</u>	
24. FUNERAL DIRECTOR <u>Donald M. Stein Hebrew Memorial</u> Funeral Home		25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1898

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CERTIFICATE OF DEATH

12690

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 47 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park 16.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center				d. STREET ADDRESS 6905 Carleton Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Betty Zane Love				4. DATE OF DEATH Month Day Year September 30 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 November 1918		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Schofield				14. MOTHER'S MAIDEN NAME Lottie Loehl			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Bacterial Sepsis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Soft Tissue Abscess (c) Adenocarcinoma of lung with metastases							INTERVAL BETWEEN ONSET AND DEATH 48 hours 1 month 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 15 August, 1967, to 30 September 67 that (X) (we) lost saw the deceased alive on 30 September 19 67, and that death occurred at 3:25 M, from causes and on the date stated above.							
22a. SIGNATURE Thomas P. Clancy				A.M. ATTENDING PHYS. <input type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Sept. 30, 1967	
22c. PHYSICIAN'S NAME (Type) Thomas P. Clancy, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 3, 1967		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR C. Glen Carter 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR OCT 4 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12682

CERTIFICATE OF DEATH

12691

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>56 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		83.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>702 South Arlington Mill Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Joseph Mahoney</u>				4. DATE OF DEATH Month Day Year <u>September 9 19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1934</u>		9. AGE (In years last birthday) <u>33 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Mahoney</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Davitt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Korean</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT <u>The Medical Record, The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>Mycosis Fungoides</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>9</u>	
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>July 15</u> , 19 <u>67</u> , to <u>September 9, 19 67</u> , that <u>X</u> (we) lost saw the deceased alive on <u>September 9 19 67</u> , and that death occurred at <u>4:45M</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Michael Emmer</u>				22b. DATE SIGNED <u>10 Sept. 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Michael Emmer, MD.</u>	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>		23d. LOCATION (City or Town) (County) (State) <u>Framingham, Mass.</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers</u> <u>1400 Chapin St. N.W. Wash, D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1500

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SEP 13 1932

12683

CERTIFICATE OF DEATH

12692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner Dr. John Ball Sept 2 1967

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> 1511		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>				d. STREET ADDRESS <u>2009 Blue Ridge Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Mayme</u> Middle <u>Markowitz</u> Last <u>Markowitz</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/1890</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Rochester, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Meyer Markowitz</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Witt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR HEMORRHAGE</u> DUE TO (b) <u>HYPERTENSIVE AND ARTERIO-SCLEROTIC VASCULAR DISEASE</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>63</u> , to <u>SEPT 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JULY 10</u> , 19 <u>67</u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Krichmar</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR MD</u>				22d. ADDRESS <u>7733 ANAKA AVENUE N.W. WASHINGTON D.C. 20012</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FRUMAN PACKARD</u>		23d. LOCATION (City or Town) (County) (State) <u>SYRACUSE, N.Y.</u>			
24. FUNERAL DIRECTOR <u>Deborah Kroll</u>				ADDRESS <u>4217-9 Ave</u>	25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

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12684

CERTIFICATE OF DEATH

12693

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suburban</u>		c. LENGTH OF STAY IN 1b <u>35 mins</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7200 Old Stage Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Marie</u> Last <u>McAuliffe</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24 1911</u> 9. AGE (In years last birthday) yrs. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland, Montgomery</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Edgar Morningstar</u>		14. MOTHER'S MAIDEN NAME <u>Mary Florrie Loy</u>	
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>James S. McAuliffe</u>	
17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STROKE</u> DUE TO (b) <u>HYPERTENSION + CORONARY DISEASE</u> DUE TO (c) <u>3 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>See</u> , 19 <u>55</u> , to <u>See</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 2 1967</u> , and that death occurred at <u>9:40</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. L. I. Donovan</u>		22b. DATE SIGNED <u>9/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. L. I. DONOVAN</u> <u>2218 WIDE AVE</u>		22d. ADDRESS <u>BETHESDA MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Beallsville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>

1888

STATE OF OHIO

REPORT OF THE COMMISSIONER OF THE LAND OFFICE

For the year ending
March 31, 1888
The following is a list of the lands
owned by the State of Ohio
and the amount of the
rents thereon for the year
ending March 31, 1888.

James A. Smith

John A. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12685

12694

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>8mo 22da</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>5906 Giberdeen Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Timothy D. McCarthy</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8 1879</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MASS.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>310-09-4443</u>	
17. INFORMANT <u>Daug.</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS GENERAL</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u> <u>YR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIVERTICULITIS OF COLON, ACUTE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>64</u> , to <u>SEPT.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 17</u> 19 <u>67</u> , and that death occurred at <u>4:40pm</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leo M. Curtis</u>		22b. DATE SIGNED <u>9-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEO M. CURTIS, MD</u>		22d. ADDRESS <u>8218 WILSONSIN AVE, BETHESDA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>New Haven, Conn.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	
ADDRESS <u>Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12504

ENTRANCE IN DEATH

12504

Remains of a person
found in a box
at the residence of
the deceased
on the 1st of
the month of
the year 1900
at the residence of
the deceased
on the 1st of
the month of
the year 1900

Remains of a person
found in a box
at the residence of
the deceased
on the 1st of
the month of
the year 1900
at the residence of
the deceased
on the 1st of
the month of
the year 1900

Remains of a person
found in a box
at the residence of
the deceased
on the 1st of
the month of
the year 1900
at the residence of
the deceased
on the 1st of
the month of
the year 1900

12686

CERTIFICATE OF DEATH

12695

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb Silver Spring,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. STREET ADDRESS 10110 New Hampshire Ave.	
3. NAME OF DECEASED (Type or print) WILLIAM PAUL McCLELLAND		4. DATE OF DEATH Month Sept. Day 9, Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1918
9. AGE (In years birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Daniel Clark McClelland		14. MOTHER'S MAIDEN NAME Mary G. Brady	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 72-16-1310	
17. INFORMANT wife Address Same as Item 2.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction - Inferior Wall. 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-6 , 19 67 , to 9-9 , 19 67 , that (I) (we) saw the deceased alive on 9-8 , 19 67 , and that death occurred at 12:04 A.M. from causes and on the date stated above.			
22a. SIGNATURE J. Blaine Fitzgerald M.D.		22b. DATE SIGNED 9-9-67	
22c. PHYSICIAN'S NAME (Type) J. BLAINE FITZGERALD		22d. ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-12-67	23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery	23d. LOCATION (City or Town) (County) (State) New Bethlehem, Penna
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR SEP 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECORDS OF DEATH

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RECORDS OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12687

CERTIFICATE OF DEATH

12696

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>6 years</i>		d. STREET ADDRESS <i>10703 Tenbrook Drive</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>10703 Tenbrook Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Guy Fidellis Mc Intire</i>		4. DATE OF DEATH Month Day Year <i>Sept 4 1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 12, 1897</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Accountant</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Scott Mc Intire</i>		14. MOTHER'S MAIDEN NAME <i>Olive Modesett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>1</i>	
17. INFORMANT <i>Edna J. Mc Intire</i>		18. ADDRESS <i>10703 Tenbrook Drive Silver Spring, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>35 days</i> <i>15 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 1, 1967</i> , to <i>Aug 23, 1967</i> , that (I) (we) last saw the deceased alive on <i>Aug 23, 1967</i> , and that death occurred at <i>8:34 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>George B Patrick Jr.</i>		22b. DATE SIGNED <i>Sept 4, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>George B Patrick Jr.</i>		22d. ADDRESS <i>9221 Colesville Rd Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Sept. 7, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 8 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MEDICAL CERTIFICATION - Cleared by Dr. Glen Carter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12688

CERTIFICATE OF DEATH

12697

1. PLACE OF BIRTH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN lb 1 week		d. STREET ADDRESS 8004 Parkcrest Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank Joseph McKenna		4. DATE OF DEATH Month Day Year September 10 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-84
9. AGE (In years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Etcher of Silver		11. BIRTHPLACE (County & State, or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Christopher McKenna	
14. MOTHER'S MAIDEN NAME Margaret Owens		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 042-05-2934		17. INFORMANT William J. McKenna 8004 Parkcrest Drive, Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocardial infarction DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 256 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-14 , 19 65 , to Sept 10, 1967 that (I) (we) last saw the deceased alive on 9-9 , 19 67 , and that death occurred at 24 M, from causes and on the date stated above			
22a. SIGNATURE John S. Rogers MD		22b. DATE SIGNED 9-10-67	
22c. PHYSICIAN'S NAME (Type) John S. Rogers MD		22d. ADDRESS 2250 Wisconsin Ave, S.W., Wash. D.C.	
23a. BURIAL, CREMATION, RENEWAL (Specify) Burial		23b. DATE THEREOF Sept. 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Wheaton, Montgomery, Md.	
24. FUNERAL DIRECTOR Warner & Humphrey Inc. 8434 Georgia ave. S.S. Md.		25a. REC'D BY REGISTRAR SEP 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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CHICAGO, ILL. 60607

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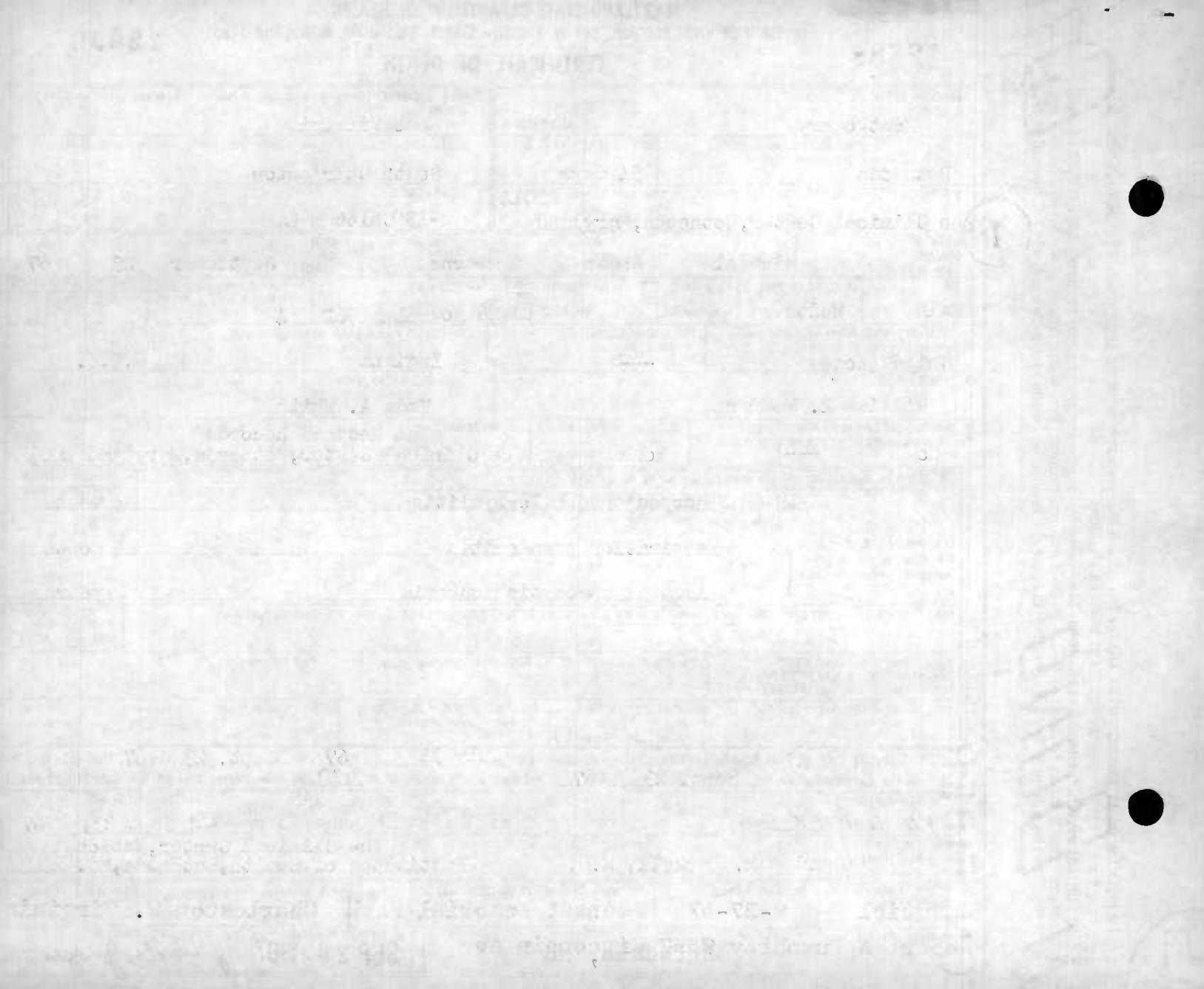
12689

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 54 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Charleston			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland				d. STREET ADDRESS 913 Chittum Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Michael Shawn Mearns				4. DATE OF DEATH Month Day Year September 23 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 November 1962		9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child (None)		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Mearns				14. MOTHER'S MAIDEN NAME Veda A. White			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Herpes encephalo-myelitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration pneumonitis</u> DUE TO (c) <u>Acute lymphocytic leukemia</u>							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 month 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from <u>July 31</u> , 19 <u>67</u> , to <u>Sept. 23</u> , 19 <u>67</u> , that the (we) last saw the deceased alive on <u>Sept. 23</u> 19 <u>67</u> , and that death occurred at <u>9:40</u> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Charles M. Haskell</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Sept 23, 1967	
22c. PHYSICIAN'S NAME (Type) Charles M. Haskell, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-27-67		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Charleston W. Virginia	
24. FUNERAL DIRECTOR Robert A Pumphrey				ADDRESS 5557 Wisconsin Ave		25a. REC'D BY REGISTRAR SEP 29 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.
Dr. Rodgine Notified and approved

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MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12690

12699

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>1303 Morningside Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise Gertrude Meehan</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Chuc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1886</u>	9. AGE (In years, lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>15</u> Min.	IF UNDER 24 HRS. Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Providence, Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Farrell C. Fitzpatrick</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Tierney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>John Meehan</u> <u>1303 Morningside Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute myocardial infarction</u> DUE TO (b) <u>1 week</u> DUE TO (c) <u>Interval BETWEEN ONSET AND DEATH</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1967</u> , to <u>Sept 8, 1967</u> , that (we) last saw the deceased alive on <u>Sept 8, 1967</u> , and that death occurred at <u>3:04 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Herbert E. Maganzini</u>				22b. DATE SIGNED <u>9/8/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Herbert E. Maganzini</u>				22d. ADDRESS <u>50 W. Edmonston Dr. Rockville</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Sept. 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pawtucket, Rhode Island</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12691

CERTIFICATE OF DEATH

12700

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN lb <u>4 days</u>		d. STREET ADDRESS <u>815 Brantford Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harold</u> First <u>9</u> Middle <u>Meeth</u> Last		4. DATE OF DEATH <u>September 4</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1897</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Post Office Clerk U.S. Post Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Henry Meeth</u>		14. MOTHER'S MAIDEN NAME <u>Martha Frincke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>218-26-1803</u>	
17. INFORMANT <u>Charlotte Bayln Meeth</u>		Address <u>815 Brantford Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>163X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>10-12 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> to <u>4 Sept</u> , 19 <u>67</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>3 Sept</u> , 19 <u>67</u> , and that death occurred at <u>1:34 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William D. And</u>		22b. DATE SIGNED <u>Sept. 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>		22d. ADDRESS <u>9006 Colesville Road Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co.</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1937

RECORDS OF DEATH

1937

RECORDS OF DEATH

RECORDS OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>Takoma Park, Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>7214 Holly Ave Takoma Park, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RAILS NURSING HOME</u> <u>1420 Maple Ave</u>		d. STREET ADDRESS <u>7424 MAPLE AVE TAKOMA, MD</u>	
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>H</u> Last <u>MENDUM</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>DUNCANNON, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>YES</u>	
13. FATHER'S NAME <u>JOSEPH C. HAWLEY</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE REUTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SAMUEL W. MENDUM</u>		Address <u>Takoma, Park</u> <u>7214 HOLLY AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>ARTERIOSCLEROSIS, GENERALIZED</u> (c) <u>15 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARKINSONISM, ADVANCED</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/19, 1967</u> to <u>9/26, 1967</u> , that (I) (we) last saw the deceased alive on <u>9/19, 1967</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>LBSnow</u>		22b. DATE SIGNED <u>9/26/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>9-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>G. Wm. Lee + Sons</u>	23d. LOCATION (City, town or county) (State) <u>300 4th St N.E. Wash, DC</u>
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME 300 4th ST NE</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

10781

(M)

SEP 27 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12693											
12702											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville						c. LENGTH OF STAY IN 1b 2 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Potomac Valley Nursing Home						d. STREET ADDRESS 429 East Diamond Avenue					
3. NAME OF DECEASED (Type or print) First Grace Middle --- Last Merry						4. DATE OF DEATH Month September Day 15 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 8, 1887		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 15 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own Home				11. BIRTHPLACE (County & State, or foreign country) Fairfax County, Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William A. Moxley						14. MOTHER'S MAIDEN NAME Susan Ellen Riley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Harry C. Merry, Sr.		Address 429 E. Diamond Ave. Gaithersburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Serum lipids PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Fr. Sept. Hip											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-12-1967 to 9-15-1967 that (I) (we) last saw the deceased alive on 9/12/1967 and that death occurred at 9-15-1967 M, from the causes and on the date stated above.											
22a. SIGNATURE W. T. Joyce, M. D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-15-1967			
22c. PHYSICIAN'S NAME (Type) W. T. Joyce, M. D.						22d. ADDRESS 4977 Battery Lane, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Funeral Home				23b. DATE THEREOF 9/19/67		23c. NAME OF CEMETERY OR CREMATORY Andrew Chapel		23d. LOCATION (City, town or county) Kienna, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE J. Berkeley Green, Herndon Va.						ADDRESS Herndon Va.		25a. REC'D BY REGISTRAR SEP 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1288

LETTER TO DEATH

12103

CONTINUED

Rockville 2 days

Potomac Valley Nursing Home

120 West Diamond Avenue

Jan. 8, 1937 80

Essex County, Va. H. S. A.

Sharon Ellen Wiley

William A. Wiley

517-12-3127 Harry C. Harty, Sr. 120 E. Diamond Ave. Alexandria, Va.

No. 10

4-15-1961

xx

1917 Battery Lane, Bethesda, Md.

W. T. Joyce, M. D.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12694

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12703

1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Bethesda				c. LENGTH OF STAY IN 1b Great Cacapon				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 270				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE West Virginia				b. COUNTY 85-3				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Cacapon				d. STREET ADDRESS 85-3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Irval				First Michael				Middle Michael				Last Michael				4. DATE OF DEATH Month September Day 6 Year 1967							
5. SEX Female				6. COLOR OR RACE Cauc.				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Dec. 14, 1931				9. AGE (In years last birthday) 35 3/4 yrs.				10. IF UNDER 1 YEAR Months 3 Days 24 Hours 15 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME George C. Youngblood				14. MOTHER'S MAIDEN NAME Cora B. Whicker				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 10				17. INFORMANT Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries multiple severe 8190 DUE TO (b) Truck accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Seconds				Seconds															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) None				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Passenger in cab of tractor trailer which ran into bridge abutment at high speed. Gasoline tank exploded and truck				20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:30 9/6 1967				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 270				20f. (City or town) (County) burned (date) None Montgomery Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 9/6/67							
ACTUAL SIGNATURE John S. Rogers, M.D.				EXAMINER'S NAME (Type) John S. Rogers, M.D.				Address (Street, city, town, or county) 1919 Seminary Rd. Silver Spring, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 10				23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery				23d. LOCATION (City, town or county) (State) Morgan County, W. Va.											
24. FUNERAL DIRECTOR Robert W. Humphrey, Bethesda, Md.				25a. REC'D BY REGISTRAR SEP 11 1967				25b. REGISTRAR'S SIGNATURE John S. Rogers															

MEDICAL CERTIFICATION

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State 170

State 170

State 170

State 170

State 170

State 170

State 170

State 170

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12695

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12704

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San & Hosp.</i>		d. STREET ADDRESS <i>1210 Ruatan St.</i>	
3. NAME OF DECEASED (Type or print) <i>Sidney Louis Miller</i>		4. DATE OF DEATH Month <i>9</i> Day <i>26</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-15-1900</i>
9. AGE (In years last birthday) yrs. <i>67</i>		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>26</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CROWNING</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Abraham Miller</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>	
17. INFORMANT <i>(Wife) Mrs Anna Miller</i>		Address <i>Seems 20th</i>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> DUE TO (b) <i>Coronary Artery Heart Disease</i> DUE TO (c) <i>Coronary Artery Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Keap</i>		22. DATE SIGNED <i>9-26-1967</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. KEAP M.D.</i>		DEPUTY MEDICAL EXAMINER <i>Wheaton</i>	
23a. BURIAL, CREMATION, or other disposal (Specify) <i>Buried</i>		23b. DATE THEREOF <i>9-27-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Hebrew Friendship Soc. Co. Bldg.</i>		23d. LOCATION (City or town) (County) (State) <i>Hebrew</i>	
24. FUNERAL DIRECTOR <i>Leibberg Funeral Home</i>		25a. REC'D BY REGISTRAR <i>SEP 28 1967</i>	
ADDRESS <i>4217-9 Ave</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1000

UNITED STATES DEPARTMENT OF AGRICULTURE

U.S. GOVERNMENT PRINTING OFFICE



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12696

CERTIFICATE OF DEATH

12705

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>--</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>30 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newport News</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			d. STREET ADDRESS <u>315 69th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Rose</u> Last <u>Mirmelstein</u>			4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 April 1913</u>	9. AGE (In years lost birthday) <u>54 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Louis Banks</u>			14. MOTHER'S MAIDEN NAME <u>Mary Levinson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure and Shock</u> DUE TO (b) <u>Sepsis (Staphylococcal) with Endocarditis and/</u> and liver (c) <u>Mycosis Fungoides with involvement of lymph nodes/</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>5 Days</u> <u>10 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>21 August, 1967</u> , to <u>20 Sept., 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>20 Sept., 1967</u> , and that death occurred at <u>5:00 M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Joseph D Croft Jr</u>			22b. DATE SIGNED <u>20 Sept. 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Joseph D. Croft, Jr., MD</u>			22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
<u>Burial-remov</u>	<u>9.22.67</u>	<u>Rosenbaum Mem. Park</u>	<u>Hampton, Virginia</u>		
24. FUNERAL DIRECTOR <u>W.G. Turbyfill Jr</u>			25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1934

CONFIDENTIAL

1934



Handwritten notes at the bottom of the page, including "The trouble of Newport News, Va." and "Newport News, Va.".

CERTIFICATE OF DEATH

12706

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 47-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 2520 10th St., N.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Edna Jefferson Moore		4. DATE OF DEATH Month Day Year 9 - 23 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1894
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Stoney Creek, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Juddi Jefferson	
14. MOTHER'S MAIDEN NAME Bettie Briggs		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 578-26-2454		17. INFORMANT Spurgeon Johnson, Wash D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) 331X DUE TO (c) Interval between onset and death 1 month		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 9/7 , 19 67 , to 9/23 , 19 67 that (I) (we) last saw the deceased alive on 9/23 , 19 67 , and that death occurred at 4 p.m. from causes and on the date stated above.	
22a. SIGNATURE Myron L. Lenka		22b. DATE SIGNED 9/23/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Sept. 27-1967	
23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Prince Geo. County Md.		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR Lalney's Funeral Home, Wash. D.C.		25a. RECEIVED BY REGISTRAR SEP 27 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

12707

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 32 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		d. STREET ADDRESS 1115 Bellview Road	
3. NAME OF DECEASED (Type or print) Hazel (NMN) Moore		4. DATE OF DEATH Month September Day 14 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 April 1924
9. AGE (In years lost birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Terrell		14. MOTHER'S MAIDEN NAME Malinda Everett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 227-46-9772	
17. INFORMANT The Medical Records		18. ADDRESS The Clinical Center, Bethesda, Maryland	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory and Cardiac Arrest 227X DUE TO desmoid tumors Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Laparotomy, excision of abdominal wall for / DUE TO (c) Gardner's Syndrome			INTERVAL BETWEEN ONSET AND DEATH 90 minutes 48 hours 40 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 13 August , 19 67 , to 14 Sept. , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 14 Sept. , 19 67 , and that death occurred at 9:20 M. , from causes and on the date stated above.			
22a. SIGNATURE Frederick R. Eilber M.D.		22b. DATE SIGNED Sept. 14, 1967	
22c. PHYSICIAN'S NAME (Type) Frederick R. Eilber, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL (Cremation or Removal) (Specify)	23b. DATE THEREOF 9-18-67	23c. NAME OF CEMETERY OR CREMATORY Shiloh Bapt. Church Va	23d. LOCATION (City or Town) (County) (State) McLean, Va
24. FUNERAL DIRECTOR James E. ...		25a. REC'D BY REGISTRAR SEP 19 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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Shirley L. Jackson
Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2201 Virginia Ave. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Melba V. Morrison</u>		4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/29/21</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Spec.-FOREIGN-SERVICE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALFRED MORRISON</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA CLARK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>286-14-3024</u>	
17. INFORMANT <u>MRS. H.M. DIEHL-JEFFERSON</u>		Address <u>ST. RED HILL, PA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO (b) <u>Adeno carcinoma of Pancreas</u> DUE TO (c) <u>no.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>67</u> , to <u>9/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> , 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. G. Lennard Gold</u>		22b. DATE SIGNED <u>9/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. G. Lennard Gold</u>		22d. ADDRESS <u>8641 Colesville, Road, S.S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>9-13-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

12700

CERTIFICATE OF DEATH

12709

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6815 FAIRFAX Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>A</u> Last <u>MURRAY</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-84</u>
9. AGE (In years last birthday) yrs. <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>York, Pa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>James Murray</u>		14. MOTHER'S MAIDEN NAME <u>Catharine Kauffelt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>068-09-3327</u>	
17. INFORMANT <u>Wife</u> <u>Theresa S. Murray</u>		Address <u>Same As Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>PARKINSONISM</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 DAYS</u> <u>3 YRS</u> <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> , 19 <u>67</u> , to <u>9/12</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9/11</u> 19 <u>67</u> , and that death occurred at <u>1A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ORLINO E. DORRAN</u>		22d. ADDRESS <u>8218 WISCOUR BETHESDA MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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